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WOMEN IN OUR AGING SOCIETY

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

COLUMBUS, OH

OCTOBER 8, 1984

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WOMEN IN OUR AGING SOCIETY

MONDAY, OCTOBER 8, 1984

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Columbus, OH.

The committee met, pursuant to notice, at 9:30 a.m., at Ohio State University, Columbus, OH, Hon. John Glenn, presiding.

Present: Senator Glenn.

Also present: Diane Lifsey, minority professional staff director; Eileen Bradner and Kathy Connolly, minority professional staff members.

OPENING STATEMENT BY SENATOR JOHN GLENN, PRESIDING

Senator GLENN. This hearing will be in order, please.

First of all, I want to welcome each and every one of you to this hearing of the U.S. Senate Special Committee on Aging, entitled "Women in Our Aging Society." It is a very special pleasure to be holding today's hearing in Columbus, and I especially want to thank the Ohio State University for making these facilities available to us.

I also want to welcome as a member of the panel this morning the person who probably does more in the House of Representatives in this particular area than almost any other Member of the House. She's chairperson of the Task Force on Social Security and Women of the House Select Committee on Aging. And that is a big responsibility, I can guarantee you. Looking into her work means looking into all of these areas of a segment of our society that is increasing in numbers and importance, and also in the problem areas that we have to look forward to dealing with in the future. Mary Rose Oakar.

Congresswoman Mary Rose Oakar, we are very glad to welcome you to the hearing this morning. And I appreciate all your efforts to get here.

She was in Louisville last night for the Presidential debate, so obviously she had to get up very early this morning to get here, and we appreciate her efforts in this regard very, very much.

I think it is especially appropriate we are conducting the hearing today on Columbus Day, the day on which we celebrate the discovery of America. The historic voyage of Christopher Columbus, of course, was made possible by the generosity and foresight of a woman, Queen Isabella of Spain. And today our interest, like hers, is to explore new worlds and chart new opportunities for the future. Specifically the purpose of today's hearing is to explore the changing roles of women in our aging society and to identify the

issues that must be addressed if women are to have new opportunities available to them in the 21st century.

In that sense, I believe that what we are doing today is in the best tradition of responsible government. For a government that is truly of the people and for the people has a responsibility to consider the long term, as well as the short term, needs of our Nation. Unfortunately, as I have discovered during my 10 years in the Senate, it is often difficult to get politicians to look beyond the next election, let alone the next generation. The purpose of this hearing, however, is to do just exactly that.

As a special nonlegislative committee, the Senate Committee on Aging has a broad mandate to study issues of concern to older Americans. Before we go any further I want to emphasize the name of my committee is the Aging Committee, not the Aged Committee. In other words, we examine not just the issues that affect the older citizens of today, but also those that will affect the older citizens of tomorrow. That means that just as we conduct investigations of such immediate problems as discrimination against older workers, nursing home fraud, Medicare solvency and income security, so must we seek to anticipate and address the incipient problems that are likely to confront and confound future generations.

To help us accomplish that goal, the distinguished witnesses who are here today will address some of the important changes that are reshaping American society and opening gaps between our future needs and current policies. And while these changes affect all of us, male and female alike, their impact is especially profound on women. To underscore that point, let me give you just a few statistics.

We all know that women's participation in our economy is growing, is changing. What many of us fail to appreciate is that women now account for 53 percent of the American work force, as compared to just 32 percent in 1960. A tremendous change over just the last couple of decades. Even more surprising is the fact that middle-aged women are the fastest growing segment of our labor force and their contribution will be more critical in the years ahead when we will confront a shortage of skilled younger workers.

Younger women now entering the work force are better educated than were their counterparts in previous generations, and are entering careers which traditionally have been dominated by men. Indeed, more and more women are pursuing professional careers, working longer hours, commanding higher salaries than women who went before them. But whether they are money makers or homemakers, all women share common concerns about their retirement years. That is how it should be. Whether they are joining a pension plan or opening a spousal IRA, women are now taking a larger role in planning for their own futures, their own future financial security.

Today, women are also increasing their participation in politics. In fact, by 1980 there were 6 million more female voters than male voters and there are three times more women serving in State legislatures today as did 15 years ago. As a nation, I think we can be proud that there is now a female Justice on the Supreme Court and that a woman has been selected as the Vice Presidential candidate of a major party.

While some women are making great strides in the quest for full fledged equality, too many others are falling below the poverty line. For these women, changes in the family and increases in life expectancy pose problems which can only be resolved by public policy. Women who are single heads of household, for example, are finding it increasingly difficult to work and simultaneously provide care for their children. Many are forced to leave their jobs and seek refuge for their families in our system of public assistance. And because their life expectancy exceeds that of men, the economic, health and social problems of the elderly are primarily the problems of women, especially for those over 80, the fastest growing segment of our aging population.

The changing role of women in our aging society has wide-ranging implications—implications for Government programs, for work and retirement opportunities, for health care, social services and for family and community life. And these changes, in turn, raise questions we must begin to address.

We know, for example, that women are no longer merely secondary workers. Their participation in the economy is vital to their families and the economy, yet their wages and career opportunities often fail to reflect these realities. Why do these gaps between the promise and reality of equal rights persist? How can we close them?

We also know that younger women now entering the work force are likely to stay longer and build up more Social Security credits and pension benefits than did women who have recently retired. Will tomorrow's female retirees enjoy the financial independence that their mothers and grandmothers failed to achieve? And, if not, how can we help them to do so?

What about women who choose to work in the home? After all, they are full partners in the productivity of our economy and strength of our communities, yet their contributions are frequently ignored. There are particular problems involved in that area. I feel that a homemaker's job is every bit as demanding as any professional job, and perhaps the most important job in our whole society. And yet we too often almost encourage people to get out of the home. And how do we take care of that? That's a very major problem. And what changes are needed in our retirement programs to reward the service of homemakers, and to ensure their retirement security, as well as those who are full-time out in the work place.

With more and more women in the work place, we also confront problems in the area of caring for the young and the elderly. Who will provide this care, and how can we ensure its quality?

Chronic illnesses, such as osteoporosis, arthritis, and heart disease, disable many elderly women. What can we do to improve the treatment of these conditions? What steps can young and middle-aged women take today to prevent them?

These are some of the questions that today's witnesses will seek to answer, and give us some enlightenment on. So let us set sail and begin our journey. After all, it is Columbus Day, and a new world beckons us ahead.

Thank you very much. [Applause.]

Congresswoman Oakar, do you have any statement you would like to make before we go to our witnesses?

STATEMENT BY CONGRESSWOMAN MARY ROSE OAKAR

Congresswoman OAKAR. Senator, I want to say how proud I am of you as our Senator from Ohio. And as Congresswoman from the Greater Cleveland area, I'm proud that you chose to serve on the Aging Committee. Aging is one of the most critical issues facing our society today. I don't know if everyone in Ohio knows this, but you are the ranking member on the minority side, and we hope some day that changes. If it does, you will be the chairman of the Aging Committee on the Senate side. You could then play a policy-making role.

I'm so delighted to be here to discuss older women's issues. I just want to say a few words about it if I can. Yesterday at the debate I was pleased that there were some issues raised relating to women and older women. Certainly women are extraordinary—Medicare and Social Security is so important to them. And as you mentioned, Senator, people are living longer, and two-thirds of all the people who are over 65 are women. We know that for women it is a catch-22 situation. Women are very concerned about what they are paid when they are younger because they know that the laws which discriminate against them when they are older could result in low pensions. So they are bound to be poor when they are older if they are not paid adequately when they are younger.

So there is a relationship between pay equity and pension reform. We know in Social Security, for example, as good a program as that is, that it still discriminates against women. Many working spouses get less than if they never worked at all. So all the money they paid into Social Security is kind of a freebie for the Government. And homemakers, as you mentioned, are very important to us.

Homemakers who go in and out of the labor force to care for children and elderly relatives are not covered under disability if they are out of the paid labor force for 5 or more consecutive years. Widows and displaced homemakers face problems of pension and Social Security inadequacy also. Reform is needed because Social Security is crucial since only 20 percent of all the women who are covered by Social Security today have any other access to a pension.

Health reform is also important for older women. We know, for example, that the No. 1 killer of older women is breast cancer. And yet we've seen the cuts in research and development. We see these cuts in research now, when we are on the breakthrough of finding a manner in which we can deal with the problem of breast cancer and other forms of cancer and possibly have a vaccine that would immunize people from this disease. We sure have enough money to blow up the world. Why can't we find a cure for cancer and other diseases, particularly those diseases that we know kill women.

While I talked about some of the problems that women face, I really feel confident that we have some very, very strong laws on the books that you helped promote, Senator. The Fair Credit Act passed in the 1970's that was so important for women to have access to credit; Civil Rights Act, title IX, that is supposed to respect equal access to education; and title VII, that relates to issues

like pay equity; and the Fair Pay Act that is supposed to guarantee proper pay in the work force.

I know you are a proponent of enforcing the law. And I am so pleased that you are taking a special look on the Senate side of the needs of what is the fastest growing population in the country, our elderly. All of us look forward to living a long life. We just want to live a life of quality. That is why having a reference to a framework by which we can formulate is so necessary.

Again, I want to thank you for your leadership and your kind invitation. Dr. Butler is just an exquisite person to have here. We are fortunate to have him in our great State's capital, and I look forward to hearing all your witnesses.

Thank you Senator. [Applause.]

Senator GLENN. Thank you very much.

Just a couple of housekeeping details here before we proceed with Dr. Butler. We had a request from the press here of when we might be available. For their information, there will be a period from 12:30 to 1:15 in the Alumni Lounge if you want to get together then for whatever questions they might have. And, also, these yellow sheets have been made available to everyone. I would like to encourage you to use those sheets, to make your comments, and appropriate comments will be extracted off of those to be included in our committee record today that will be printed and be available all over the country in libraries, and so on.

We couldn't have everyone on the program here today, with the time constraints that we have, that might have wanted to testify. But we would like to have the information from you and your observations on the problems that we are talking about here today for the record.

Also, on the Aging Committee, we have a number of studies that we have done in the past. They are about issues of importance to older Americans. We've brought some of those information papers along today. They are available at the desks outside the entrance to the hall here, in the lobby, and you can pick those up. And if you would like to be put on the mailing list to receive information regularly, please let us know that on the yellow sheet, also, if you would give that to one of our staff members. Diane Lifsey heads up the minority staff on the Aging Committee. We have other members of the staff here today, also. They will all have name tags, yellow name tags similar to the one that Diane has here. So any questions or comments you might have today about getting information, or any suggestion that you have, we would appreciate you getting in touch with one of the staff members here.

One introduction I would make, I guess, before I get to Dr. Butler, and that is, I think I will hear about it if I do not introduce my wife, Annie, who is right down here. [Applause.]

And, now, let's get on with the hearing here this morning.

I don't know of anyone who could head up our hearing witness list to any more advantage than Dr. Butler. Dr. Butler is the former director of the National Institute on Aging, part of the National Institutes of Health [NIH], in Washington. And perhaps, I don't know, Doctor, maybe even more significant than that is you are the founder of the geriatrics department at Mount Sinai School of Medicine, New York City. We were talking at breakfast a few

moments ago, and I believe this is the first such institution—one of all of our 127 medical schools, you told me, across the whole country, to have a department of geriatrics, which shows how far behind we really are in this Nation of ours in addressing this problem. We have specialties in all of our medical schools in almost everything that you can possibly think of or dream up as far as physical difficulties; and yet that difficulty which all of us are—whatever our age—heading toward, some of the difficulties of geriatrics, problems of the elderly, are not being addressed adequately. And just to put Dr. Butler's work in a little better perspective, also, I think more than any other person probably in this whole country, he has single handedly been responsible for making people aware of the problems faced by older Americans. And that came about through his work and through his writings. In particular, he won the Pulitzer Prize, which didn't come easy, I can guarantee you, but he won the Pulitzer Prize in 1976 for his prize winning book, "Why Survive? Being Old in America." And he is much in demand on lecture and consultation circuits, not just in this country, but all over the world. We were talking at breakfast a while ago about programs in Holland and Sweden, and so on, that he is thoroughly familiar with. He works very closely with those people.

So, it is a real pleasure to welcome him to our hearing this morning and have him as our leadoff witness. And Doctor, we look forward to your remarks to give an overview of our aging society and the issues particularly affecting the older women today and tomorrow. So, Dr. Butler, I would like to personally welcome you here.

STATEMENT OF ROBERT N. BUTLER, M.D., CHAIRMAN, RITTER DEPARTMENT OF GERIATRICS AND ADULT DEVELOPMENT, MOUNT SINAI SCHOOL OF MEDICINE, MOUNT SINAI MEDICAL CENTER, NEW YORK, NY

Dr. BUTLER. Thank you very much for that most generous introduction. And good morning to Congresswoman Oakar and to Senator Glenn, and good morning to everyone.

It's a pleasure to be in Ohio. The last time I was here was in preparation for the White House Conference on Aging. And, at that time, also, I visited Ohio State here in Columbus, and, of course, you should know that Ohio has been the first State in the country to devote funds directly to its medical schools for the development of geriatrics. It's been a bell weather State in that regard.

I couldn't help but react a bit to some of the comments already made. We don't have a department of the future in the United States. And because we have annual budgets, and we don't have 5-year plans, or multiyear budgets, I think we rarely do what Senator Glenn has done; namely, create an occasion such as this where we can think ahead, think ahead to a time that is of great importance. Obviously we cannot wait, for instance, until the baby boomers, of whom I see at least a few here in the audience, reach golden pond before we begin to act. We can't wait until 2010, 2020, to begin to create divisions, programs, departments of geriatrics to see that we have well trained physicians and scientists to be the innovators in health service delivery, the creators of new programs of research, and to be certain that no one, no one graduates from a

medical school, nursing school, a social work school, that isn't properly prepared to meet the challenge that the baby boomers are going to pose in 2020. We can't wait until 2020 to really make some efforts to deal with the many debilitating diseases of old age.

Osteoporosis, Alzheimer's disease, cancer, many of the other conditions, that hadn't even been recognized as important in old age. They were rather silent diseases. We certainly can't wait until the next century to develop the types of alternatives to expensive personally painful periods at the end of one's life that may be spent unnecessarily in nursing homes because we failed to develop appropriate options.

I also think it is important that this hearing has identified the gender gap in aging. The gender gap is a topic that we've heard a lot about in recent times. But here I'm talking about the Medicaid spend-down that's so humiliating, frequently to women, as they carry their husbands through to the last moments of life with the spend-down that often leads to pauperization. And we must not forget that some 75 to 80 percent of the people who are in nursing homes are women. There are 1.3 million people over 65 in nursing homes. As a matter of fact, now more patients on any given day in nursing homes than in general hospitals.

The second gender gap has already been referred to by Congresswoman Oakar, that is the inequities of Social Security. After all, in 1935, when Social Security was passed into law, 83 percent of American women worked at home. They worked, but they worked at home. So you are seeing dramatic changes in society, in the lives of women, in the nature of employment which requires of us the appropriate revision of Social Security.

The third important part of the gender gap is kind of a curious one with pluses and minuses: The extraordinary difference in life expectancy between the sexes by nearly 8 years. The life expectancy gender discrepency will grow even greater. By projections into the next century, it will be about a 10-year difference. As I say, it is a mixed blessing. Many positives but many problems.

The fourth kind of gap, or aspect of the gender gap, is the research gap. We are not really studying many of the diseases that particularly afflict women. Osteoperosis was mentioned by the Senator. Cancer was mentioned by Congresswoman Oakar. Consideration of longitudinal studies was one of the other occasions I had the pleasure to participate in hearings of Senator Glenn, called, "How Old Is Old." It dealt with the longitudinal studies which are the means by which we can learn so much about how people change over time by repeated measurements of the same individuals.

Most of the studies, most of the longitudinal studies have not emphasized the lives of women. We need to understand the differences in the creation of illness, and the more importantly, perhaps the creation of health, as we look at the differences between the lives of men and women. And now to my more formal remarks.

To call ourselves "an aging society" is appropriate. But the term does need clarification. It would be a mistake to think of an aging society as one in decline, one that is stagnating and going senile. Unfortunately, some people transfer to society an image that is going out of fashion when applied to individuals.

An aging society is measured objectively in several ways: Its median age and its age composition or structure. The median age of a society is the age below which, and above which is found half the population. Age structure refers to the distribution of people by age. That is, the proportions in various age brackets, such as zero to 19, 19 to 65, 65 and older.

If anyone thinks that the term "aging society" refers to a society in which most people are elderly, let me point out that this is simply not true. For the United States, the median age will move up only modestly between now and the next century. The median age now is about 30, with about one in nine Americans aged 65 or more. In 2011, the first of our 70 million baby boomers will reach 65. At that time, the median age of our society is expected to be about 37. At that time, the median age of our society will then be comparable to the structural fact that about one out of five Americans, or about 20 percent, will be over 65.

Now, our country, in fact, has been an aging society throughout the beginnings of the century. In the United Nations terminology, a young society, such as the Third World, has an elderly population of under 4 percent. A mature society is between 4 and 7 percent and an aging society as 7 percent or more.

Japan, for example, now has a lower percentage of older people than we do, 9.8. But it is the fastest growing aging society in the world. Their men and women have the longest life expectancy, and by 2010, 22 percent of their population will be over 65, a full decade before ours. This morning, Senator Glenn and I discussed the importance of our comparing notes between societies. Certainly, we could learn much from Japan, and they could learn much from us.

The point of my concern here is simple. We must not, however inadvertently, create stereotypes in discussing an aging society. If we do, we will close off an enormous potential for creative development. We will, for example, overburden ourselves with nursing homes for a population that could be active, but rather is induced to be passive dependent, and at tremendous cost to society, as a whole, and, of course, tremendous personal anguish.

Just as many people are coming to perceive that individual aging is a mixture of pluses and minuses, ups and downs, so they must also see that population aging is a frontier. Many opportunities lie beyond. I prefer to accentuate the positive, the unprecedented increases in absolute numbers, and proportions of older persons in our country is a result of extraordinary social and medical progress. Our society has experienced an historic watershed demographic change. I prefer to use the term longevity revolution. I know revolution is often used glibly, and can be an overused term. But revolution means a fundamental change, and we have seen one. For example, we have gained in this century 25 years in life expectancy. From 3000 BC, the bronze age, to the year 1900, which was a 5,000-year period, we gained 29 years in average life expectancy. So we have almost achieved in one century what was achieved in the previous 5,000 years.

Many people are now living into their eighties and nineties. How, then, can we reconceptualize and build and alter contemporary private and public institutions to better serve the needs cre-

ated by that demographic revolution. Now, that revolution was, in part, traceable to declining birth rate. There have been also great changes, as you know, in living standards and sanitation, nutrition, and medical care.

The remarkable reduction in maternal, childhood, and infant mortality rates stands out as the beginning of this longevity revolution. And just to give you a little feeling as to how different it was, almost yesterday, 1915 to 1919, 703 women died in childbirth for every 100,000 births—703 women for every 100,000 births. Today it's 8.9 who die for every 100,000 births.

I really think we forget yesterday's successes and the dramatic changes that have occurred. The virtual elimination of maternal mortality, has, in effect, substituted widowhood for widowerhood. In saying this, I want to add immediately the great need for us to be more sensitive and effective in the minority community. Black and Hispanic communities still have an inappropriately high infant maternal mortality rate compared to the majority of Americans.

The second phase in the demographic revolution refers to chronic diseases. I'm not sure how many people recognize that there has been a 25-percent drop in deaths in heart disease from the last decade. A 25-percent drop and a 40-percent drop in deaths from stroke in the last decade. The second phase of the demographic revolution tells us how much we must do to further support research and chronic illnesses, 50 percent of all cancers occur after 65, and yet little attention is spent on either therapeutic interventions in the 65-plus age group that have cancer, or on understanding the fundamental biological mechanisms that relate to why cancer is more prone to develop in aging.

Now, all of this has led to a kind of a dilution of association of death to different periods of life. We have seen a dramatic change. In 1830 in the United States, one out of three newborn babies only lived through their sixties. One in three. Today, 8 of 10 newborn babies live out what we take for granted, at the moment, as a full and natural life. What a difference.

Take the lives of women. In 1870, just 114 years ago, of women who survived past 15, who didn't die of chicken pox, diphtheria, or scarlet fever, of those who survived past 15, only 44 lived out what we take for granted as a natural life course today. Dramatic changes in the lives of the women. And this triumph should not be overshadowed by our failure, so far, to adequately meet the change through imaginative Social Security reforms and developments, the financing of Medicare, the appropriate solution for the long-term care problem.

Against this backdrop of triumph and foreboding, it's no wonder that the potential and social value of aging research are often ignored or misapprehended. I believe that we can increase survivorship further. The natural lifespan appears to be about 110. The average life expectancy at birth of both sexes now is 74. We have some 35 years of human potential to realize. And I mean human potential of high quality, not human potential of decrepitude.

I have no doubt that we will increase average life expectancy as a result of further successes and by medical research, both disease oriented research and aging oriented research. And I also believe

that research holds great promise of relieving us from the fears of more years of less living. Just think for a moment about Alzheimer's disease. Who heard of it 5 or 6 years ago.

And now we have moved from spending something like $700,000 devoted to try to unravel this most common of the senilities and are devoting some $35 million with some results, not breakthroughs in terms of therapy as yet, but a better understanding of the underlying cause which can give us hope, real hope for the future.

What do I mean by disease oriented and by aging research? In its classical form, disease oriented research is directed at finding an external cause of a disease and intervening to stop or to modify its destruction. Poliomyelitis offers an example of a disease virtually eliminated in this country as a result of vaccination based on biomedical research on a family of viruses. It's also a very good example of fundamental research. The three individuals who found a way to grow polio virus in tissue culture are names we have not ordinarily heard of; Enders, Weller, and Robbins. We all know Salk and Sabin, and should have great respect for their contributions to bringing vaccines to bear. But without basic science, without being able to grow the virus in tissue culture, the application of the vaccines would not have been possible. And how many of us remember that it was only 23 years ago, 1961, that we had our last polio epidemic. In those days, parents were afraid to let children go to a swimming pool. Such a change.

Aging research, on the other hand, concentrates on normal changes of the organism over time, searching particularly for underlying biological mechanisms of senescence. The objective is to maintain, restore and assist biological systems that have lost strength and regularity with age.

Another way of illustrating it is our immune system. By the time we reach our 60's, we have about one-tenth of the immune strength which we had when we were teenagers. If we can then find ways to maintain the vigor of that immune system in dealing with external pathogens or the internal migration of cancer cells, we would in one swoop be able to create a stronger biological system that deals with an array of noxious problems, and not have to pursue one specific disease at a time.

And now, what is the relevance of all of this for the world of women and the importance of this hearing? As I said, women outlive men dramatically. And it is projected that this discrepancy will grow even further. The majority of America's 27 million population of elders is female. It is entirely correct to speak of the feminization of old age. Ignoring the problems of old age means ignoring the problems of old women far more than that of old men. The additional years for women present a mixed blessing. Here I'm indebted to Myrna Lewis whose work on older women and health is the basis for my brief comments. They are significantly different and, in some ways, greater problems of health for women than for men. Nearly 80 percent of residents of nursing homes are women. Women report both more acute and chronic illnesses and disabilities than do older men. Women die of a lower rate when they are ill.

Long-term institutional care of older people, mostly older women, constitutes one of the fastest growing items in the American health care budget. Social vulnerability is an issue for older women who also have no mates or close relatives to care for them. Most older men, in contrast, are married. The average age of widowhood is 56 years, which means that the average wife is likely to have two decades or more of widowhood until she can remarry. Some 25 percent of women 70 or older have no living children. So those who say that families abandon older women should realize how much it is a consequence of life itself, childlessness, and of the deaths of husbands and companions.

Older women have fewer financial resources for health care than older men. And these resources must obviously cover a longer lifetime. If the older woman is a member of a racial or ethnic minority, the vulnerability to poverty is even greater.

Public and private arrangements to pay for health care in this country are more suited to acute inpatient hospital care, than to chronic outpatient and long-term care services, which are services very much needed by the elderly, principally women. The trends in Federal and State budget cutting and health care fall exactly on the services most needed by older women.

We've had a $19 billion Medicare cut in the last 4 years in the present administration, and a $5 billion cut on the Federal side of Medicaid. A profound reduction in services.

Finally, older women face the intertwined prejudices of sexism and ageism in health care, a tendency to see the elderly as burdensome problems. You will recall that I mentioned this remarkable shift forward insofar as illnesses and death is concerned from the younger years to the later years, is it therefore so surprising that it is going to shift forward health costs? Would we want it any different? Would we wish to return to the days of the illnesses of children and women? I don't think so. So this shift forward means that costs have been shifted to the later years, and we must not blame the survivor, or blame the victim, the women.

Clearly our society has to adapt to its aging in ways of support and nurture rather than degrade and stifle. Adjustment is needed not only in health care, but also in the financing of later life, the provision of social supportive services and the elaboration of work and other productive roles that lend dignity and self-sufficiency to all of us as members of families, communities, social and business organizations and religious groups.

Let me talk a little about some needed institutional changes. We need change in male oriented pension, Social Security and other financial supports for later life. The Citizens' Council on Earnings Sharings, and the Save Our Security organizations, have both supported appropriate changes in Social Security to bring us up to date with the realities of the defeminization of aging.

In the biomedical research realm, there is a clear need for increased and well supported study of aging. The gender-determined difference in average life expectancy deserves intensive investigation.

The importance of these questions for us as an aging society and as individuals, is not reflected, in my opinion, in the funding, both in the private sector and in the Federal sector. For example, spend-

ing at the National Institutes of Health, the National Institute on Aging, which is the newest of the institutes, receives only 2 percent of the entire NIH project. And as the Senator mentioned, it's somewhat shocking to me that only one medical school in the country has, so far, established a full-scale department of geriatrics.

The National Institute on Aging under the directorship of Dr. T. Franklin Williams, is identifying molecular biology of aging and the frail elderly as key priorities. First, to help us understand fundamental biological mechanisms of aging that predispose all of us to diseases and disabilities in later years. The second priority, the frail elderly, predominately women, are an increasing group among the fastest growing population group in our society, mainly those 85 and above.

It is this group that bears much of the suffering of senile dementia of the Alzheimer's type. The time is now to prime the longevity revolution for a victimless old age in which premature death and disability for men and prolonged poverty and disability for women become rareties. In an aging society, the baby boomers will find it easier, not harder, to reach and enjoy the golden pond.

Thank you. [Applause.]

[The prepared statement of Dr. Butler follows:]

PREPARED STATEMENT OF ROBERT N. BUTLER, M.D.

I want to thank you, Senator Glenn, for the opportunity to give this testimony on the subject of this hearing, "Women in Our Aging Society." I congratulate you on holding these hearings, which I believe will help our society in planning for the 21st century.

To call ourselves "an aging society" is appropriate. But the term needs to be clarified. It would be a mistake to think of an aging society as one in decline, one that is stagnating and going "senile." Unfortunately, some people transfer to society an image that is going out of fashion when applied to individuals.

An aging society is measured, objectively, in several ways: its median age and its age structure. The median age of a society is the age below which and above which is found half the population. Age structure refers to the distribution of people by age, that is, the proportions in various age brackets, such as zero to 19, 19 to 65, and 65 and older.

If anyone thinks that the term "aging society" refers to a society in which most people are elderly, let me point out that this is not true. For the United States, the median age will move up only modestly between now and the next century. The median age now is about 30, with about one in nine Americans aged 65 or more. In 2011, the first of our 76 million baby boomers will reach age 65. At that time, the median age of our society is expected to be about 37. Structurally, about one in five Americans will be aged 65 or more by about 2020. Even in 2020, four in five Americans will not be elderly.

Moreover, our country has been an aging society for much of the 20th century. In United Nations terminology, a young society has an elderly population of under 4 percent, a mature society has between 4 and 7 percent, and an aging society has 7 percent or more.

The point of my concern is simple: we must not, however inadvertently, create stereotypes in discussing "an aging society," or "population aging" (as the demographers call it), or "societal aging" (as the social scientists call it). If we do, we will close off an enormous potential for creative development. We will, for example, overburden ourselves with nursing homes for a population that could be active but rather is induced to be passive, dependent, and infantile, at tremendous cost to society as a whole.

Just as many people are coming to perceive that individual aging is a mixture of pluses and minuses, ups and downs, so they must also see that population aging is a frontier. Many opportunities lie beyond.

I prefer to accentuate the positive. The unprecedented increases in absolute numbers and proportions of older persons in our country is a result of extraordinary social and medical progress. Our society has experienced historical demographic

trends of a revolutionary character. I like to refer to these trends as a "longevity revolution." For those who think "revolution" is all too glibly used these days, let me say that the term is fully justified in population aging. For we have experienced a fundamental change in the length of life available to us, more and more people live to the eighties and nineties. This is more than most of us deliberately prepare for and less than we commonly contemplate when we evaluate how well our major public and private institutions serve our needs.

This demographic revolution is traceable to declining birth rates, improved living standards, and better sanitation and medical care The first phase of the revolution produced remarkable reductions in maternal and childhood mortality rates. This achievement is quintessential to the subject of these hearings on "Women in Our Aging Society." The virtual elimination of maternal mortality meant, eventually, the substitution of widowhood for widowerhood in our society. In short, mothers outlived fathers.

The second phase of the demographic revolution comprises progress in preventing death from chronic diseases that appear in late life. In the last few decades alone, mortality from heart disease declined 25 percent and from stroke 40 percent. However, this does not mean a corresponding reduction in disability: victims of heart disease and stroke survive; they continue to need help even as they continue to be productive for themselves and others.

The demographic revolution has diluted the association of death with all periods of the lifecycle. It has intensified the relationship of old age and death. Instead of one of every three babies surviving into their sixties, which was the case in 1830, eight in ten of today's babies survive into old age.

That is a triumph. With that triumph—overshadowing it for many people who do not remember the days of high maternal mortality—comes the dread of old age due to the association with disability, despondency, and dependency as well as death.

Against this backdrop of triumph and foreboding it is no wonder that the potential and social value of aging research are often ignored or misapprehended. I believe we can increase survivorship further. The natural life span appears to be about 110. The average life expectancy at birth for both sexes is now 74. We have some 35 years of potential to realize. I have no doubt that we will increase average life expectancy as a result of further successes in biomedical research, both disease-oriented and aging-oriented. I also believe that research holds great promise of relieving us of the fears of more years but less living.

What do I mean by disease-oriented and aging research? In its classical form, disease-oriented research is directed at finding the external cause of a disease and intervening to stop or modify its destruction. Poliomyelitis offers an example of a disease that virtually disappeared in this country as a result of vaccination based on biomedical research on a family of viruses.

Aging research concentrates on normal changes in the organism over time, searching particularly for underlying biological mechanisms of senescence. An objective is to maintain, restore or assist biological systems that have lost strength and regularity with age. To the researcher in aging, an episode of illness may be the manifestation of vulnerability in a biological system. Indeed, the appearance of several diseases together or in sequence may suggest an underlying change. I believe the pursuit of an underlying change promises to be more economical and powerful than dealing with one disease at a time.

In this discussion, I have touched on the longevity revolution and dangers of negative stereotyping, the factors promoting longer average life expectancy, and biomedical research, particularly aging research, as a basis for improving old age. The relevance of these points to women surely needs little elaboration. Women outlive men. The majority of America's 27 million population of elders is female. It is entirely correct to speak of the feminization of old age. Ignoring the problems of old age means ignoring the problems of old women far more than of old men.

The additional years for women present a mixed blessing.[1] There are significantly different, and in some ways greater, problems of health for women than for men. Nearly 80 percent of residents of nursing homes are women. Women report both more acute and chronic illness and disability than do older men, but women die at a lower rate when they are ill.

The long-term institutional care of older people, mostly older women, constitutes one of the fastest growing items in the American health care budget. Social vulnerability is an issue for older women, who often have no mates or close relatives to

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[1] Here I am indebted to Myrna I. Lewis Older Women and Health: An Overview. In Women in Health: The Journal of Women's Health Care, in press 1985.

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care for them. (Most older men, by contrast, are married.) The average age of widowhood is 56 years, which means that the average wife is likely to have two decades or more of widowhood unless she can remarry. Some 25 percent of women aged 70 or older have no living children. Older women have fewer financial resources for health care than older men, and these resources must cover a longer lifetime. If the older woman is a member of a racial or ethnic minority, the vulnerability to poverty is all the greater.

Public and private arrangements to pay for health care in this country are more suited to acute inpatient care than to chronic outpatient and long-term services, which are services very much needed by the elderly, principally women. The trends in federal and state budget cutting in health care fall exactly on the services most needed by the older woman.

Finally, older women face the intertwined prejudices of sexism and ageism in health care. A tendency to see the elderly as "burdens" and "problems" in the American health-care system converts older women into scapegoats.

Clearly, our society has to adapt to its aging in ways that support and nurture rather than degrade and stifle. Adjustment is needed not only in health care but also in the financing of later life, the provision of social supportive services, and the elaboration of work and other productive roles that lend dignity and self-sufficiency to us all as members of families, communities, social and business organizations, and religious groups.

Let me talk a little about some needed institutional changes.

We need change in male-oriented pension, social security, and other financial supports for later life. The Citizens' Council on Earnings Sharings, cochaired by Tish Sommers and Arthurs S. Flemming, and the Save Our Security (SOS) organization cochaired by Wilbur J. Cohen and Dr. Flemming, are supporting changes in the Social Security system as it affects older women.

In the biomedical research realm, there is a clear need for an increased, and well-supported effort to study aging. The gender-determined difference in average life expectancy deserves intensive investigation. What can be learned from women that may assist men in attaining longer lives? What are the impediments to a 110-year lifespan for both sexes? How can we maintain and restore older people faced with chronic illness, and how can we prevent it?

The importance of these questions for us as an aging society and as individuals is not reflected, in my opinion, in spending for the National Institute on Aging. This newest of the National Institutes of Health receives only 2 percent of the entire NIH budget. The Baltimore Longitudinal Study of Aging in the National Institute on Aging should have a major increase in funding; this is needed in order to fulfill its goal of having, under study at any one time, 100 women and 100 men in each decade of adult life. The sex difference in life expectancy should be a key research priority. Studies should include genetics and in immune and endocrine factors. Also to be studied are gender differences in lifestyle and behavior, including the apparently greater capability of women to share feelings and to develop a greater range of friends and other social supports. These psychosocial factors may help account for difference in life expectancy.

The National Institute on Aging, under the directorship of Dr. T. Franklin Williams, is identifying molecular biology of aging and the frail elderly as key priorities. Genetics research will help us understand fundamental biological mechanisms of aging that predispose people to disease in later life. The frail elderly, predominantly women, are an increasing group among the fastest growing population group in our society, those aged 85 and older. It is this group that bears much of the suffering of senile dementia of the Alzheimer's type, a leading NIA research topic.

The time is now to prime the longevity revolution for a victimless old age, in which premature death and disability for men and prolonged poverty and disability for women are rareties. In an aging society, the baby boomers will find it easier, not harder, to reach and enjoy golden pond.

Senator GLENN. Let me ask a couple of questions. I would invite Congresswoman Oakar here to join in with this. Usually in our hearings in Washington we have set periods of 10 minutes and go 10 minutes back and forth so that everyone gets an equal time period. But I think we can conduct this a little less formally here today. And I would like both of us to get involved here with the questioning as we go along, and take our lead from each other on some of these things.

Doctor, I would like to know, from your medical look at this whole problem, is frailty inevitable, or are we just pushing things up to a higher age? Is it going to be a continuing problem forever, or can we look forward to a time when the medical requirements of old age might even be diminishing if we do the proper research right now?

Dr. BUTLER. I am glad you pointed that out. Behind that, I think, is your recognition that, fortunately, we are beginning to have increasingly sturdier, vigorous, healthier older people, as well as that significant subgroup of frail older persons. It's always so hard to describe something as complex as aging without getting too superficial. So you are right in pointing out that we do not only have a frail elderly, and it is possible that with time, the social, the institutional, the religious organizations, the productive roles that older people can assume, may turn out to be much more dominating than the medical side, as important as that may be.

Senator GLENN. Assuming that we are all going to need help sometime, and I am assuming that we all will, we've seen tremendous changes just within our own lifetimes, it seems to me, on how we take care of old age. And let me give an example. I think even when I was a younger person growing up in New Concord, families pretty much grew up and lived in that community by and large, and children took care of the elderly, and it was more of a family responsibility.

And now, the way things have developed in my own family would not be unusual today. Annie and I, of course, live in Washington, DC. Her mother, who is 89 years old, and was going to be with us here this morning—unfortunately got a flu shot yesterday and it sort of zonked her out, and she couldn't be here with us this morning. She was looking forward to this from a personal self-interest standpoint obviously. So she couldn't be with us this morning.

Annie and I are in Washington, her mother lives here in Columbus. Our daughter lives in Colorado, our son lives in San Francisco. We are spread out over the whole length of this Nation of ours. And so it is a whole different problem perhaps just geographically, and this is not unusual. And if the figures I recall are correct, I think 20 percent of our people move to a different domicile each year, and 13 percent move across State lines. We are a mobile, flowing society, and families no longer grow up and stay in the same community.

Responsibilities for the elderly, and so on, are shifting then somewhat. And what do you see replacing those family responsibilities, and is it going to be just a Federal responsibility, just a State, just a community, or from your studies in this area, what do you think is the best way to take care of what is obviously a national problem?

Dr. BUTLER. Well, my hope is that it will be, in a sense, all of the above. We can begin to have an appropriate merger of private sector institutions, religious groups, local clubs, and organizations, like Lions Clubs, plus the communities, the States and the Federal Government, because the problem is complex. It's very easy to go to Sweden, as I have, or the Netherlands or Japan, and to come back and say how wonderful they are and how terrible we are. But

when you think about it a little, you realize they are very small countries.

In Holland, if a family moves, say a son or daughter goes to Amsterdam, it's still just a 2-hour car ride to see mother or grandmother in another community in the Netherlands. I think we have to find ways of strengthing the family rather than just saying, oh, my, we are not doing very well because we are a highly geographically mobile society, which we are. It was in Cleveland, I believe, that some studies of the General Accounting Offices showed that American families take care of their older members.

Senator GLENN. More so than other countries.

Dr. BUTLER. We had not compared studies, that I'm aware of, but as you and I talked this morning, it might be an interesting thing to undertake some comparative studies between some of the other lands and our own. I guess my bottom line is, how can we strengthen the family, how can we provide respite services, how can we provide a variety of homemakers, home health aides, day care services, so that we don't tempt the family out of exhaustion to abandon the older family member?

Provide ways of strengthing the family, including long distance social services, so that if one's mother decides to live in Phoenix, AZ, or Sun City, you can know that there is some contact person for that community to help maintain your parent.

Congresswoman OAKAR. Of course, Doctor, as usual, you just gave a fabulous overview of the future, and pluses and the minuses. I'm so thrilled that you are still so involved in the study of geriatrics. It is incredible that we only have one medical school that has as a priority geriatrics training.

I'd like to be practical for a moment, if I can, because I like to look to the future. But I'm a little bit interested in what you do here and now.

We have Medicare as the No. 1 program for older women, and it only serves 40 percent of older persons' needs. And it deals in what you just talked about. It takes care of the catastrophic problems but not the day-to-day and long-term difficulties. You can't even get a free physical without having to pay for it. It isn't covered under Medicare. It doesn't make sense. We don't give free medicals to the elderly. We are always talking about cost containment, but I don't hear a lot of people talking about what we ought to do to offer the other needs that Medicare does not cover. So what would you like to see the ideal medical plan cover?

Dr. BUTLER. You put your finger on it when you said, can't even get a preventative checkup. So we wait for a person, a man or woman, to become ill before we are able to introduce effective treatment. We don't provide outpatient medication. We don't provide for long-term permanent care. It's obvious that Medicare, however wonderful—and it is. It is a very important precious beginning. Nonetheless, it was set up as though people were about 40-years old.

It was not set up with the longevity revolution in mind with the realization of particular claims that older people are going to have to make on social, as well as medical services. I personally believe to get to a very practical answer to your question, without any new

dollars, we are going to have to do some shifting of funds and payments within medicine.

I think it was the Senate Committee on Aging that brought out the fact, maybe 6 months ago, that something like 640 cardiac surgeons in the United States working 3 mornings a week earn somewhere close to a half-a-million dollars a year. I'm not trying to begrudge cardiac surgeons. I'm sure I will be mobbed by a cardiac surgical group as I leave here.

But on the other hand, we say that the first time technology is employed, it may be more expensive. But is it still necessary for $5,000 an operation to occur after all these years since coronary bypass operations were first done? Aren't we going to have to shift present resources to be more in line with functional assessment and maintaining case management, with seeing that people can remain in their own homes? I don't think we dare take any more from the beneficiaries. We've gone too far, in my judgment, already.

It's time now for we providers to have to expect a certain amount of cost containment, ourselves. Cost containment can't, in consequence, be shifted to older people, especially older women, as was pointed out, already are frequently at the margins, economic margins of existence.

Congresswoman OAKAR. I'm thinking of introducing a Medicare bill that deals with cost containment, but that would also provide preventive service coverage: C, D, and F; C to cover prescriptions, and D to cover physicals and free blood pressure checks, and things that would prevent the more serious illnesses from occurring. You just cannot get a lot of sympathy for that kind of bill. Everybody talks about how it would cost more. I think it would push the price down. And I would like to explore that with you personally a little further.

Dr. BUTLER. What I meant by the redirections of existent funds so you won't think I gave an off-the-wall answer, there is a committee at the Institute of Medicine of the National Academy of Sciences dealing with physician payments and how physician payments might be changed. After all, when original fee structures were negotiated through the various fiscal intermediaries, since 1965, the introduction of Medicare, they weren't etched in stone forever.

There is no reason why there can't be appropriate renegotiations of fee schedules and reimbursements. We don't reimburse a team. We should. We don't reimburse a paraprofessional that can do many of the things a physician does, such as take blood pressure readings. I think we are simply going to have to bite the bullet in a fiscally conservative manner. We have to operate within certain availability of funds. We are talking about 10 percent of GNP. Can't we redirect much of that 10 percent in a way that is much more, first, effective, second, cost appropriate, and third, more in keeping with the changing age structure of our society?

Senator GLENN. Your comments on cardiac surgeons' costs reminds me of Mike DeBakey, the famous heart surgeon in Houston.

Dr. BUTLER. He was a good friend of mine.

Senator GLENN. He's a good friend of mine, too. And I was interested enough in medicine—in fact, I'll share a little secret. I'm a

frustrated doctor at heart. I've been fascinated with medicine ever since I was a child. My son followed up that interest, even though I never made it to being a doctor. In fact, I'm not sure I'm smart enough to get into med school these days.

But Dr. DeBakey was a good friend of ours. I watched him operate a number of times in Houston. He has a different way of taking care of charges. When they finish up the operation and want to know what the bill is, he says, "whatever you think it was worth."

That means he gets $100,000 for his heart institute from some people, and maybe $100 from somebody who can't afford it. I thought that was a very good way of taking care of it.

The idea of preventive medicine which Mary Rose brings up very properly, I think is one that I've had a long interest in, too, from another standpoint. NASA, in trying to set up programs for astronauts in space, has had a very extensive program of preventive medicine. In other words, how do you keep well people weller, even, and this is something that we don't get into with Medicare and Medicaid and programs like that, at all, because we wait until—in effect, with medicine, we wait until the wreck occurs. We wait until there is a problem, a difficulty, and then we try to correct whatever it was instead of preventing it to begin with. And Medicare doesn't even get into that. So I think your legislation would be very apropos.

Let me get into a slightly different area while we still have a little bit of time. We tend to think of institutional care, and nursing home care, and things like that—and a lot of people, I'm sure there are many people in the audience here today who look at the possibilities of being institutionalized, being put in a home in their elderly senior citizen years, with some abhorrence. They would far rather stay in their own homes and maybe they need a little bit of help, and maybe somebody needs to come in and check once in awhile, or a telephone network needs to check on status daily, or something like that.

Would you give us your comments, please, on home care for the elderly versus institutionalization, and what directions you think we should go there? And are there costs involved? Do we have any estimates of what costs would be in each direction? What are your comments on that?

Dr. BUTLER. There has certainly been a great deal of fear that if there were to be new benefits structured within Medicare to provide home care, that it might bust the bank. And there have even been fears that families who are somehow already taking care of older people would now decide they didn't have to, and simply call upon the public provision of home care to replace them.

As far as I am aware, from studies in the United Kingdom, Sweden and elsewhere, where there are more home care services available, that has not happened. That's comment No. 1. And it relates to the earlier discussion, the ways in which we need to strengthen family life, and strengthen the capability of the family to be able to maintain an older person at home.

Second, I think realistically we can introduce a kind of circuit breaker. There may be a better term for it, some way that will identify when a patient has reached a certain point of expense, where more services are going into the home, homemaker, home

health aide, visitations of physicians, an increased medicine bill, et cetera.

And, at that point, let's say some figure, 60 percent, 75 percent, of the institutional cost in that area. When that point is reached, there would be a reassessment of the situation, or a call for one, to see if, at that point, as a consequence of economy of scale, it is appropriate for institutional care, because institutional care is not and should not be seen as bad. There are times when it's absolutely essential. And there are some outstanding homes. You are going to hear from one director of one of those homes, Mr. Kaplan, this afternoon.

And clearly there are many homes that need support. We can't see it as a kind of an either or, but as a set of possibilities to which any of us may need to turn.

Congresswoman OAKAR. John, would you yield on that point?

You mentioned home health care. Dr. Butler has talked about strengthening the family. As we know, most older people who happen to be living, are living alone. We also know from the Cleveland study you referred to, which I am a little bit familiar with, that one severe problem is elder abuse. Very often, families through the stress of modern age, and unfortunately, take their frustrations out on older members of the family who rely on financial and health care. We talk a lot about children being abused, but we don't often talk about elderly being abused. If we had the proper support system like home health care that would help families meet the needs of their relatives, we would be able to eliminate many unnecessary problems. And as much as we have so many wonderful things going, it is true that other countries do have that support mechanism. We would really end a lot of the frustrations and the end result, the abuse that takes place.

For the first time, we finally passed a bill, the Child Abuse Amendments of 1983, which establishes a national clearinghouse to take a look at the factors contributing to elder abuse. The clearinghouse will enable us to gather the data we need to support our findings of elder abuse.

So it is real important to have home health care as you mentioned, Senator, and all the kind of support services that do not really cost the kinds of moneys people think. In fact, they save a lot of money because they, in a sense, do prevent institutionalization when unnecessary.

Senator GLENN. There are all sorts of things we can do. We've been studying on the committee, and I know you've done similar studies in the house, on congregate care. This is a community where people can still live at home, but they need some medical attention, so they get together maybe within a four- or five-block area, or half a dozen block area, 2 days a week or 3 days a week, and perhaps nutritional concerns can be addressed there, and medical concerns, and it's a way of keeping people in their communities at far less expense than even having one person out of that community in a home someplace. And, so there are some ways maybe we can save money and still give the kind of help and the kind of care that our elderly all deserve.

Doctor, before we move on to the next panel here, I'd like to ask you to address one other thing that was brought out in a recent

report that was done by the Population Reference Bureau. And the title of the report was "Death and Taxes: The Public Policy Impact of Living Longer." In that, they came out with a recommendation that more research money should be focused on diseases that kill men.

There is a plot behind this here. It gets good. In order to improve the economic status of women.

The idea was that—I'm not sponsoring it now, that is part of the report. The idea was this: that if men live longer, it would narrow the gap between male and female life expectancy, keep couples together longer and improve the economic status of women. In other words, the men live longer and so there is a better economic status for women. What is your view of that? I'll put you on the hot spot.

Dr. BUTLER. Well, I think there should be movement toward equalization of life expectancies between men and women, among the various racial and ethnic groups, as well. There are these disparaties which are striking. We should know--this is a matter of biology—perhaps 40 percent or more of the difference in life expectancies between the sexes may be genetic. In every known animal species, with a few exceptions, the female outlives the male. Stronger, the right stuff, I guess. [Applause.]

Senator GLENN. If they are going to outlive us, that's the wrong stuff. [Laughter.]

Dr. BUTLER. Fine. Sixty percent. Sixty percent. We all have something to do about it. It's not genetic. That's where we have a very real responsibility, and that is where both of your emphases on health promotion and disease prevention are so important. For example, Congresswoman Oakar may not have seen the most recent statistics which actually show that cancer of the lung has now surpassed cancer of the breast as the killer of women. And yet we haven't done a very good job in reaching young women and discouraging them from tobacco.

So there are many lifestyle things we could introduce that would help equalize the lifespans of men and women. There is a greater amount of alcoholism and cirrhosis of the liver in men than women. Greater tobacco intake. Greater high risk behavior, activities, greater exposure in the job, in the work place to toxins and to various forms of potential disability. So there are changes in lifestyle and behavior that could already help to equalize the lifespans. It would be, I think, best for all to have that equalization.

Senator GLENN. If I could ask, I keep saying just one more, but there is one more that I do want to ask because I think you are uniquely situated to address it. And I know we are over on our first panel. If the second panel will please be patient with us, we will get to you in just a minute here.

You've had a unique opportunity to travel to many nations around the world and see how they are addressing some of these same problems that we are trying to address here. Are there some things that we could learn from these other nations? Are they all just bound up in money, I guess that is number one. Are they just fundamentally going to cost more so we just have to figure out ways if we are going to do these things, how are we going to pay for them? Is that our principal problem? Because we know a lot of things we could do, some of which we've discussed here this morn-

ing. Is it just a matter of providing the money that we can afford to do it or have the will to do it? What has been your observation of the way other nations around the world are taking care of this problem, and what can we learn from them? Do you have some suggestions there?

Dr. BUTLER. Well, I think that some specific looks at provision say of home care among different countries would be useful. Second, the degree which research agenda has been altered. Third, to look at what you get for your money. Japan spends seven percent of its GNP on health care as compared to our 10 percent. What are they doing that's different than what we're doing.

The provision of practical changes in service delivery can be striking. In India, maternal and child centers are frequently being altered to include older people. So you have the same physical infrastructure. You don't build a new building, but you simply use, at different times of day, the same facility to now bring in an increasingly older population.

So I think, without going into a huge agenda now, we could look at many different areas on the financing side, the provision side, on the education side, and the research side that would indicate that we could learn from other countries and they could learn from us. Japan, for example, has chairs of geriatrics, the United Kingdom does, Sweden does, and much more than we do, and they are much smaller countries, in theory. So we could learn. We also have made some very important contributions and discussions with leaders of geriatrics of other countries would be a 2-way street.

Senator GLENN. How do we compare with other nations? Do we compare favorably or unfavorably? Are there other nations doing a much better job in providing a secure and healthy old age, elderly age? If so, how are they doing it?

Dr. BUTLER. I think that the Scandanavian countries and Japan are probably doing a better job. And one of the things that shocks me, frankly, is to see the front page of Newsweek, January 1983, showing one young person holding up nine people who are getting grayer as you get to the top. Or the cover of Forbes Magazine about the same time period, that said, "Can we afford our older folks?" That is a terrible threat, a terrible anxiety—provoking a set of messages for our older people.

I may be wrong, because one can get wrong or unclear ideas from sampling from trips to foreign lands, but I don't think that kind of concept appears in the European, or in the Japanese media, where older people are, in a sense, regarded as if they are being a burden to society. I think there is a sensibility here, a cultural value that we are somehow missing. We just have to change. It's this youth oriented country, perhaps.

Senator GLENN. I'm familiar with some of that in Japan. I've been chairman of the East Asian Subcommittee on Foreign Relations and I have done a lot of traveling back and forth to Japan. And having spent time there before I was in the Senate, I was out there in the military, I know the Japanese attitude toward the elderly is one of great honor, dignity, and they take a lot more family responsibility toward the elderly. And how we can reingender that in our society is a little bit difficult, I think, but as you

pointed out, it's a different geographical problem. It's a smaller country.

You can go halfway across Japan in a couple of hours, on the Tokaido bullet train out there, for instance. So it is much easier for a family's responsibilities to be exercised than it is if they are thousands of miles apart in this country.

We are going to have to get on. Doctor, I thank you very, very much. And I would ask you, if you would, please, to join us here and be a member of our panel here. And I'm sure we can benefit from your questioning as well as your answering questions. So we do appreciate it very, very much, your being with us today, and if you will, join us.

Dr. BUTLER. I will be very happy to do that.

Senator GLENN. We will have a break here for about 5 minutes, or so.

[Whereupon a short recess was taken.]

Senator GLENN. If everyone could be seated, we will get on with the hearing.

I'm particularly pleased that we have with us today Dolores Snyder, Marjorie Jenks, and Jeryl North. And all the names may be different, but they are all one family, and it is three generations of one family. And so we thought this would make a unique opportunity to address some of the problems of women from the perspective of a three-generation family. And so I want to thank all of you for your participation today.

Following them will be Dr. Mildred Seltzer, also part of this panel. Dr. Seltzer is director of education and training, and associate director of the Scripps Foundation Gerontology Center at Miami University in Oxford, Ohio, and has been involved in the academic field since 1949 in this study of gerontology. Dr. Seltzer has done extensive research on older women, and will help us identify the myths, the stereotypes about the women that we must work to eliminate. And—eliminate the problems, that is, not eliminate the women. [Laughter.]

Whoever the staff member is who put the words in that order, I want to speak to you a little bit later.

We are particularly happy to have one family with us today. And I think it would be good if we led off with Mrs. Snyder, if you could start off with your testimony, and Mrs. Jenks, and then Mrs. North. You each have separate testimony, and we welcome hearing what you have to say. And then we will go on to Dr. Seltzer.

STATEMENT OF DOLORES SNYDER, COLUMBUS, OH

Mrs. SNYDER. My name is Dolores Snyder. I was widowed about a year-and-a-half-ago. Shortly after my husband's death, I sold my home and moved to Columbus from New Philadelphia, OH, where I had lived for 75 years. I moved to an apartment in a complex operated by national church residences, which is only a few blocks from where my only child and her husband live.

My father was a coal miner and we didn't have much money. I did not finish high school, but dropped out and went to work clerking in a store. When my father became ill, I was, for some time the only support of my mother, father, and brother. I was married

rather young, had a child and was divorced. I married for a second time when I was 28, and my husband and I set up housekeeping during the depression.

Like many other men during the depression, my husband was unemployed for a long period of time. We lost the house we were trying to buy because we could not meet the payments. Finally, my husband found work on a WPA project and we rented a house.

My husband spent most of his working life as service manager at a local gas station and garage. The station moved back and forth over the years from company-owned to individually-leased, so that by age 56 he had not built up enough time under any system to qualify for a pension. Finally, about age 56, my husband secured a job as a timekeeper with a new industrial plant which had moved to New Philadelphia. He worked there for about 9 years and 8 months. When he was 66 years old, he was called in by management and told that he would have to retire. He was let go a few months prior to completing 10 years with the company. With 10 years employment, he would have become eligible for a pension.

My husband found another job immediately, and worked until he was past 70. He was also drawing Social Security, and during this time, we saved every cent we could. I was 11 years younger than my husband, so we had quite a time lag before I was able to draw Social Security, too.

We had been able to buy a small house by borrowing the down payment from my daughter and her husband. I paid them back with money I earned clerking in a small grocery. Fortunately we had our house paid off by the time that rent and heating costs began to climb.

During the Depression, I did housework for other people. But once my husband was employed, I stayed home with my daughter. During this period I had another child who died when she was about a year old.

When I was 37, my daughter graduated from high school and left home. Over my husband's objections, I got a clerking job and worked until I was in my fifties. Thereafter, I did some sewing at home for friends and acquaintances. When I was 62, I applied for Social Security and found that I had worked enough to draw on my own small account.

I had only one brother, and he never married. I visited him frequently, and much to my surprise, began to realize that he was becoming an alcoholic at age 70. In his entire life he had rarely drunk alcoholic beverages, but now he began to drink large amounts of beer. I knew he drank because he was depressed, but nothing I could say seemed to stop him. As his health deteriorated, I obtained meals-on-wheels for him, but he left the food uneaten. He finally fell and broke his hip. And when he was admitted to the hospital, I was told that he was suffering from malnutrition. The doctors felt that he could not return to living alone, and I could not take him into my one bedroom home. He went from the hospital into a nursing home. I sold his home and possessions to pay his bills, but within a year or so, he was on Medicaid. I visited him each week in the nursing home, and although it was not a very fancy facility, I must say the staff there gave him good care. He died about 2 years after entering the nursing home.

It was my husband's often expressed wish to me that he not have to go to a hospital or a nursing home. In the last year of his life, when it became evident that he was failing, he asked me to promise not to take any drastic steps at the end to prolong his life. I made a conscious decision the last few hours before his death not to call for help. He died peacefully at home with me at age 86.

I had a marriage in which for most of it my husband was the decisionmaker and money manager. As he began to age our positions reversed somewhat, and I began to make some of the decisions. I find it interesting to see that in my daughter's and granddaughter's marriages, they have been more equal partners with their husbands. Although I know my husband loved me, he never felt women's opinions counted for much.

After I moved to Columbus in 1983, I wrote the first check that I had ever written. I now manage the money we saved and the money from the sale of our house. My Social Security check covers much of my living expense. After a lifetime of economizing, it is a habit I cannot break.

I often think how many years we were only an illness away from financial disaster. The fact that both my husband and I remained in good health for as long as we did is a large part of why I am as well off as I am today. My savings do offer me some peace of mind, but I often worry that an illness will strike and that will make me dependent, and I know if I must go to a nursing home, what I have will not last long. I hope that circumstances will allow me to leave my daughter a small inheritance.

I recently went to the doctor because I was not feeling too well, and I had not had a checkup in years. I have had to deal with Medicare forms, and I must say, I find it confusing.

I have joined a senior citizens group at a church across the street from my apartment, and I am making new friends to replace the old ones I left behind. There is a nutrition site at this church, but I have not felt the need to use it as yet.

I have a friend who takes me places during the week. I have an old car, and since I find it hard to adapt to traffic in a large city, I drive only to the grocery near my home. I do not like to think of the day when my friend, who is older than I, will no longer be able to drive, for our outings help keep life interesting.

My daughter and her children make me a part of their life. I try to remain as independent as possible. Since they all work, I do help them by doing their sewing, mending and any other way I can.

This is the first time in my life I have ever appeared in public like this. But I was willing to come and tell you about my life because I think it is typical of the lives of a lot of people who reached adulthood in the depression.

My husband and I worked hard and economized all of our lives. We tried to be self-sufficient people, but I know that without Social Security we could not have accumulated enough for me to live independently as I do today. I am very thankful such a system exists. [Applause.]

Senator GLENN. Thank you, Mrs. Snyder, very much.

For the first time giving a statement like this, I think you are eligible to participate in Presidential debates.

You did a good job, and quite seriously, though, you pointed out some of the difficulties, what would have happened to you if there had been a catastrophic illness in your family, or you had come down with something that would have eliminated your financial reserves and how you had approached this.

We hear at the committee in Washington repeatedly, as I'm sure Mary Rose has in the House, the difficulty of dealing with Medicare forms, and we have difficulty with all of the Government forms. I don't know how we can correct that and still make certain that everybody that needs help, gets help. And that we don't have a lot of people getting help that should not get help, so that we deplete the system, and that's the problem. You try to get that balance, getting information on forms that you need to get and still see that it gets to the proper people. So that is a difficult one, and one complaint which we have all heard a number of times over.

Mrs. Jenks, would you give your testimony, please?

STATEMENT OF MARJORIE JENKS, COLUMBUS, OH

Mrs. JENKS. I am Dolores Snyder's daughter, Marjorie Jenks. I have been married for 36 years and I am the mother of four children. I was born in 1926, so my entire childhood was in the depression years. Not that I knew there was a depression, I just thought things always were that way.

I did well in school, and I wanted badly to go on to college. My family not only did not have the money to help me, but my father also thought women did not need a college education. To quote him, "They just get married and have babies anyway."

Since World War II was still under way when I graduated from high school, I entered an intensive Government training program for secretaries to work at Wright-Patterson Air Force Base. However, the war ended during my training and I returned home for a few months. I remember that I never considered staying in that small town. If I could not go to college, I could at least go to a big city. I came to Columbus, worked part time and attended a business college for a couple of months. I then found a full-time job in a State agency as a secretary.

I met my husband soon after he returned from the navy, and I was married when I was 20 years old. My husband went to the university under the GI bill, and I continued to work and support him while he got a degree in education.

Once he graduated, my husband offered to help me if I wanted to get a degree. However, his beginning teacher's salary was even less than what we had had with the GI bill and my salary, and I could not face another 3 or 4 years of having nothing. I did not realize then to what extent that decision would determine the course of my life. Like many other women in that period, I never seemed to consider my life as extending past raising kids and keeping house.

We both worked for a few more years and saved all we could. My husband built our first house doing most of the labor himself. Finally, at age 27, I quit work and had my first child. Once I quit working, my husband began what was to be 15 years of not only teaching, but also doing subcontracting, or whatever else he could find. To make extra money. He worked much of this period 50 to 60

hours a week. We had both agreed that we did not want me to work with small children.

Years later, when the time came that he no longer worked such hours, it took a couple of years for us to work him back into the family.

Between ages 27 and 35, I had four children. Actually, my 30's seem sort of a blur to me now of PTA, Boy Scouts, Campfire Girls, orthodontists, doctors, and worries and more worries about being able to meet bills. These were in many ways satisfying years emotionally with my children, but somehow I sort of seemed to lose myself.

Finally when I was about 42 my last child entered the first grade. I began to feel restless. The organizations and clubs I belonged to in my 30's didn't seem very interesting to me anymore. I had lost confidence in my office skills, and I really couldn't conceive of working 40 hours a week 50 weeks a year with the workload I still had at home.

Finally, through a friend, I heard that the suburban high school near me was hiring educational aides, the pay was not good, but the hours certainly were. I worked there for the next 7 years, 9 months a year, 7 hours a day. My small salary began to ease our financial problems.

When our oldest daughter graduated from high school, we were not in a position to help her. She worked and paid for her entire college education herself. We have been able to give more help to each succeeding child.

My 40's were years in which I began to discover myself again. I became something other than someone's mother. My confidence and job skills improved, and by the time I was 50, I was ready to move to a better paying position.

I felt well, and it never really occurred to me that anyone would find me too old to hire. I just never thought of it. I began answering advertisements in the newspaper for which I could meet and even exceed the requirements. However, after giving my employment history and dates either over the phone or by mail, I was never called for an interview. This puzzled me because there was supposedly a shortage of qualified secretaries.

I remember then how when I was in my middle 20's and worked in a law office, we used to run ads for secretaries stating they had to be 35 years or under. I began to wonder why I hadn't questioned that policy.

Finally, I simply presented myself at the personnel office of a very large international corporation which had opened a large facility near my home. Many of the graduates from the high school at which I worked were obtaining clerical jobs there at salaries higher than what I was making after 7 years. I interviewed with a clever personnel officer who told me that though there were entry level jobs available, I would not be happy working there as I was overqualified, and they had very few jobs which required skills as good as mine. She was so clever that it wasn't until I was in the car on the way home that I realized that I had not said I didn't want an entry level job. She said I didn't want it. I smiled to myself when in the last month or so I picked up the newspaper and saw an article saying that this company has been accused of a long-

standing policy of age discrimination. I now doubt that they wanted to put me under their pension plan at age 50.

I finally heard of a secretarial opening with a State agency through a friend. I interviewed, was hired, and have been employed there for 6 years now as an administrative secretary. Although I do like my job, there is nevertheless the knowledge that this is probably it. I cannot conceive of going out into the job market again at 57.

Fortunately, because I did not plan it that way, the years that I had with the State in my first job, the years I spent in the school, and the job I now have, all combine under one public employees retirement system. At age 60 I could retire with 20 years of accumulated service.

My husband retired this past year at age 59, to do something he enjoys, refinishing and selling antiques. We had always looked upon Social Security as a supplement to my husband's retirement income. For years he paid into the Social Security System on his part-time work, thinking he would get at least the minimum social security. The minimum has since been done away with. I had always thought I would draw one-half of his Social Security, until a few years ago the rule was passed that offset my one-half of his Social Security against any public pension I would draw.

A couple of years ago, I began paying into Social Security on a small antique operation I do with a friend thinking I could obtain enough quarters to draw my own Social Security. It bothers me when I hear rumors that possibly my own Social Security and my husband's may both be offset against our public pensions. It's a little unsettling to have the rules of game changed while you are still playing.

Fortunately, the retired teachers' pension system is excellent. I don't foresee problems unless we live too long and inflation erodes our pensions. His is an excellent system in that monthly payments to me will continue in the same amount should I outlive him.

The last few years have been the best years we ever had financially. We were not able to save any money while raising four children, and compared to the years we struggled, these years are a relief. Like my mother and father, we have been lucky in that our health and our children's health have been good.

When my children were small, I used to wake up many times at 3 o'clock in the morning and worry because I knew my parents were not very secure financially, and should they need help, we were in no position to give it.

I am very conscious today that nothing lasts forever, and I try to remember to enjoy the present, because in many ways these are some of the best years of my life. My children have turned into my friends. I still have my mother. I have a job. I have a good marriage. Everyone's health is good, and we can afford little luxuries we've never had before.

Every so often in the last few years, either my husband or I have turned to the other and said something to the effect that it's been a long struggle. We've made our share of mistakes, but isn't it nice that it has all turned out so well. [Applause.]

Senator GLENN. Thank you, Mrs. Jenks.

And now for Mrs. Snyder's granddaughter.

STATEMENT OF JERYL NORTH, PLAIN CITY, OH

Mrs. NORTH. I'm Jeryl North. I'm 29 years old, married and the mother of one child, 16 months old. I work 4 days a week as a claims representative for the Social Security Administration.

Although I may not have always thought so at the time, as I have aged I have come to realize when hearing and seeing how some children are abused and neglected, that I really did have a good childhood.

Somehow my parents instilled in me at a very early age that I would go to college and hold a job outside the home. Although my parents did not stress earning power as a reason to go to college, I certainly thought it was.

As early as the fourth grade I was extremely interested in anything having to do with money. I believe that that was because the problems I saw in our family centered around the lack of money. I saw money as a solution to a lot of problems. I never had the opportunity to see money as a cause of problems.

Although I knew I would go to college, I never expected my parents to pay. I saw a job as the means to go to college. I never considered student loans because I don't like to owe money. I got a job during my senior year in high school and worked half of each day and on weekends. I saved almost everything I earned.

With enough by graduation to get a good start on college expenses, I decided to spend some of my money on a trip to Europe. I felt that a life of hard work in school and on the job awaited me, and this was the celebration at the end of my youth. I felt I might never again have the money or time for this experience. During college, I worked on weekends and summer breaks to get the money to support myself during the school year. I lived both on campus and in the area surrounding campus during those 4 years.

I didn't know where I was headed, but I did know what courses interested me. And, after 4 years, I had a degree in sociology. I had thought of going to law school, but as my graduation grew near, I couldn't bear the thought of 3 more years in college. And my money didn't seem to go as far as when I had started 4 years before. After graduation, I continued working at a waitressing job. But fortunately, I did well in the Federal Civil Service exam and had my present job within a year.

After I had worked a few years, I got married. Within a couple years, we purchased an older home and began saving money so we could have a child. I saved my sick and vacation days so I could stay home as long as possible after our child was born. I returned to work 4 days a week after 4 months of maternity leave. I knew there was no alternative, at that point. My husband is a teacher and works on the side selling antiques with my father. We have a high mortgage payment, although our house is very modest. Our interest rate is 16½ percent, and we also put extra money on the principal each month so as to have it paid down as far as possible before I have another child.

Leaving my child with babysitters has been the worst emotional experiences, even though I have good babysitters. I was the oldest child in our family and my mother did not return to work until I was 14 years old. I remember how much it meant to me to have my

mother there when I came home from school. I'm sure that memory influences my decision today.

I plan on having another child in a couple of years. I want to quit, at that point, stay home until both children enter school. At the time I quit working, I plan withdrawing the money paid into the Federal Retirement System. I will use the money to pay off, or at least significantly reduce our mortgage.

At one time, I would never have considered withdrawing my contributions to the Federal Retirement System. But now that new Federal employees are covered by Social Security, I am considering it. I would be one of the last group of Federal employees to draw from the old Federal Retirement System, and that thought scares me. At least under Social Security, I would be with millions of people whose voices would be heard, not a few thousand retired Federal employees who would have little power.

One of my worries is that when I want to return to work I will be discriminated against because of age. I don't want to return to my present job, but I would like to work for the Federal Government. In my experience I find the Federal Government's hiring practices to be truly nondiscriminatory. I feel I can always apply for a Federal job and be judged on my qualifications and not my age.

Possibly because I work where I do, I have given much thought to retirement. In the 6 years I've worked for the Social Security Administration, I have seen many changes, some for the better, some for the worse. I personally don't like the Government pension offsets. I have read Congress' reasoning for offsets. When Social Security was enacted it was supposed to be a base for retirement income, and people were expected to build on that base. It seems to me that with pension offset, the purpose of Social Security is gradually being defeated.

I deal a lot with welfare agencies, and Social Security's objectives and rules are becoming alarmingly similar to welfare. Alarmingly similar for those who have worked and planned, not for those who haven't.

Because I don't find much security in Government-administered programs, my husband's and my long range planning includes investing what money we can in areas which will not count against any retirement benefits we might receive in the future.

I am glad that there are now opportunities for women to work outside the home and move into fields that were traditionally male. However, not all women have the same needs and wants. There must be many women like myself who like to work outside the home, but who want to be with their children in their early years. Sometimes it seems to me that we are approaching a period when because of economic necessity and rising standard of expectations, many of these women will not be able to find the wherewithal to leave their jobs for those few years.

I do not want to devote my life entirely to my job or to my children, and I'm attempting to find a way of satisfactorily fitting both into my life. [Applause.]

Senator GLENN. Those are excellent statements, all three.

And I think if you think back on what was said in each one of those, you see what was developed over the past couple of genera-

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tions. It has gone from where you were just expected to be in the home and not do much outside the home to where there were conflicts both ways, and then when you were old enough you really couldn't get into what you wanted.

Now you run into a different set of conflicts with responsibilities of the children and what you want to do as a family, and so on, and it is a whole changing set up. And I think that is very well brought out in your statements.

We will now hear from Dr. Mildred Seltzer.

STATEMENT OF DR. MILDRED M. SELTZER, DIRECTOR OF EDUCATION AND TRAINING, SCRIPPS FOUNDATION GERONTOLOGY CENTER, MIAMI UNIVERSITY, OXFORD, OH

Dr. SELTZER. My name is Mildred Seltzer, and I'm at Miami University in Oxford, OH.

As I listened to all three women, I kept thinking about how people who stereotype other people should not be surprised that the stereotypes don't always fit. We are all very, very different from one another. And, as I listened, I also thought of the ways in which we are similar and dissimilar from one another, both in ages and stages. Since I tend to fall somewhere between you two older women, I'm facing some of the same problems and some different ones.

My focus today is on several of the myths and stereotypes about old women and the consequences of these for old women of today and tomorrow, as well as some of the major issues facing today's old women.

One of the major difficulties we have in talking or writing about old women is who we are talking about. If we talk about all older women as a general category, we blur some significant differences and do a disservice to many older women. If we talk about single individuals, we blur and ignore the problems that large numbers of older women have. I am going to focus on old women in general. When people focus on old women in general, it's almost ritualistic to begin by painting an objective and demographic picture of older women, their numbers, economic situations, health characteristics, and other characteristics, particularly, as Dr. Butler pointed out, their greater life expectancy as that of old men.

We know there are more old women than old men. We know that the majority of these women are widowed. We know they have more chronic diseases than old men and that they live alone often at or below the official poverty line. This last fact is particularly true of minority old women. Dr. Butler has cogently pointed out elsewhere that the problems of old people are essentially the problems of old women. Their biological advantage combined with their social and economical disadvantages has led me to describe old women as the powerless elite. I want to talk about the myths and stereotypes describing this powerless elite and what happens to the old women in our society by focusing primarily on these two characteristics, powerlessness and eliteness.

To a large extent, the powerlessness arises from the nature of our society. Our culture is repleat with stereotypes about older women. We are familiar with the more common ones and the de-

scription they provide us about the nature and character of old women. These stereotypes and pictures range from little old ladies of considerable assertiveness asking "Where's the beef?" to Oil of Olay filling stations; from pictures of stooped over old women suffering from arthritis or osteoporosis, to sexless, unattractive old women taking pain killers. Such ads are sufficiently discouraging to many of us, although the world according to AARP is more positive. But for the really dismal and dreadful portraits of old womenhood, nothing beats medical ads. Bag ladies and wicked witches of the West look elegant compared to the disoriented and downcast old ladies, sometimes referred to privately as "crocks," in need of psychotropic drugs, tranquilizers and wheelchairs. To be seen through the eyes of the medicine man and to anticipate a future in their hands—although there are some good ones—is, indeed, a nightmarish and horrifying experience.

Stereotypes about old women are either all negative, as in the medical ads I have just referred to, or all positive, as in the friendly consumer oriented ads of magazines geared to older Americans. Occasionally, the treacley television commercials of kindly old ladies pinching toilet paper, making lemonade on hot days, and looking bereft at the loss of an American Express card, add to our body of visual stereotypes of old women.

As an old woman, I had always hoped to be spared the extremes of all good, or all bad, and spared, too, the obligation to be different because I am an old woman. It would be nice to be a person, without stereotype, without media hype, and particularly without the over-simplifications that are involved in stereotypes. This, however, is apparently not an option right now. If one lives in a society, one is apt to be influenced by the cultural beliefs of that society. And, influenced, those of us past "that certain age," are, or else why be embarrassed to come out of the closet and say how old we are?

The fact that we are flattered to be told, "You don't look your age," and dismayed to be referred to by the airline hostess as madam, indicates that we have bought into the belief that old women are unattractive, that it is better to be young than old, and that, in fact, there is something wrong with having achieved a specific chronological age. I've never found out what's wrong about it, but I know that it's faintly embarrassing and certainly uncomfortable to be defined as an old woman.

There are both personal and social consequences of stereotypes. On a personal level, we feel disquieted having achieved whatever age is defined as old in whatever environment we find ourselves. Sometimes being old is 30, sometimes it is being 40, sometimes it is in your sixties. But always, it is older than that implicit yardstick against we are measured, the young and the beautiful. Usually the young and beautiful are 5-feet 8-inches tall, and weigh 100 to 110 pounds.

Beauty is not in the eyes of the beholder, it is in the adjectives of youth. As a result, instead of being proud of our faces and bodies, we are somehow embarrassed by the fact that we have lived long enough to be defined as old. As individuals, most of us have integrated and assimilated the social definitions of what it means to be old. We have done so, unquestionably, and without asking why it is all right to be an older man. The older man is viewed as attractive,

powerful and in high prestige positions, while a woman of the equivalent age is not. Car ads may show older distinguished men surrounded by young women, not older distinguished women surrounded by young men. It rarely occurs to us that perhaps there is something wrong with a society that defines being an old woman as "A crime against nature," while older men go on to "bigger and better" jobs.

As older women we have accepted the assumption that there is something indecent about "our bodies, ourselves" and, as a consequence, we are not only reluctant to accept ourselves as old, but as Lillian Troll points out, we believe other old women are also uninteresting, dull, and unattractive. So we are unwilling to accept older women as friends, colleagues, or even interesting strangers.

Individually then we feel powerless in the face of stereotypes about us. The feeling of powerlessness spreads to other areas of concern—those in which the persistence of stereotypes renders old women even more powerless. I want to focus on two aspects of this; one economics, and the other health.

In 1981, 15 percent of the families headed by women 65 and over had incomes below the official poverty line. Almost twice the percentage of that of families headed by older men. The situation for older black women was even worse. Thirty percent had incomes below the poverty line. And for those black old women who lived alone, 64 percent lived below the poverty line. While the economics of old womanhood have improved somewhat in recent decades, there continues to be both problems and questions about what will happen in the future. Despite the woman's movement, women's pay for equivalent jobs still is not equivalent to that of men's. Moreover, pension coverage for women is not so extensive as it is for men. And because there is a relationship between work history and pay in retirement benefits, the greater a woman's work continuity and the higher her pay throughout her labor force participation, the better off she is going to be in old age. Yet, we know that the continuity of work patterns for many women is not great. Their pay is not high, and consequently, they carry into retirement lifetimes of deprivation with little, if any, likelihood of improvement in old age. We know, too, that minority old women are likely to be poorer than other old women.

If some of this sounds like bad news there is still additional bad news. For example, the increased numbers of younger women on AFDC roles reduces the number of years these women will have in the labor force. That, in turn, means that their old age will be like that of their young age; economically deprived. The "feminization of poverty" is alive and well in old age.

In our society, to be poor is to be powerless, and to be old and poor is to be doubly powerless with little opportunity to remedy the situation.

Let me turn attention now to the health area focusing, in particular, on physicians' stereotypes about older women and the results of this for older women's sense of competence. Aside from the stereotype of old women as "crocks" and "bags," there are other demeaning and depreciating aspects of being an old woman patient. Frequently, doctors call old women by their first names, rarely, if ever, by their titles. Their complaints seem unnecessary

and they are viewed as hypochondrical. Yet, the "after all, what did you expect at your age," women do have physical disorders. Frequently, these are undiagnosed and untreated because of these views of old women. It is bad enough to be unable to afford medical care, even with Medicare, to be unable to get to a physician because there is no transportation. But it is even more demeaning to see the doctor only to be treated with a lack of respect and concern. The fact that some women's normal biological functions, such as pregnancy and menopause, are treated as diseases, I think sometimes reflects doctors' attitudes toward women.

Good health is important particularly in that it influences other areas of life. Without good health, the ability to work, to interact with people and enjoy life is strongly impaired. The fact that physicians often view women's health concerns as expressions of hypochondriasis or of old age suggests a sexism compounded by ageism. An assumption that biology is an untreatable destiny results in medical practices that reveal a somewhat less than adequate understanding of older women's physical and mental health problems. Consequently, doctors' treatments of old women often reinforce women's negative self-perceptions and feelings of powerlessness.

Stereotypes replace science and implicit definitions of incompetence replace feelings of potential competence. Despite physicians' vows to cause no harm, their behavior often can result in patients' increased sense of powerlessness.

There are other areas of powerlessness; in nursing homes, in the market place where women are the invisible customers of unattractive products, and the visible ones of con artists—but, as old women we are also the elite, the potentially politically powerful, and the "exceptions that prove the rule."

I want to turn attention then to the elite side of the powerless elite. We have already noted that old women, despite everything else, are apparently biologically elite when compared to men. Old women also have the potential for becoming elite in other ways through taking initiative in changing the world in which we live. Our model is of the fairy godmother, often an older woman, who is instrumental in her behavior. Fairy godmothers bring about changes and always for the good.

Older women are organizing through OWL, the Gray Panthers, the senior centers and in resident councils of long-term care facilities. They see the positive rather than the negative side of "where's the beef," and they beef about discriminatory behavior.

If David Guttmann is correct in his finding that as women age they become more assertive, then there is hope that old women, as well as old men, will run for political office in the future, and, in this way, become more powerful rather than powerless.

There is hope, yet it is well to remind ourselves that the lumping characteristics of stereotyping blind us to the need to focus attention on such populations of older women, those who are particularly powerless. These are frail elderly women, the women without families and without friends, the poor, a vast number of whom are minority women. Our concern also should be not only the old women of today, but with future old women. We know that a lifetime of poor economic situations and poor health will carry over into old age. Unless, therefore, we focus on current problems that

younger, as well as older women, are experiencing, we can be assured that we will continue to have numbers of older women with problems in the future. We need to focus our attention on some new categories of old women, such as older women veterans. We don't know very much about them and we really ought to.

The societal forces and problems that we operate in our system are experienced individually. How we "adapt" to old age depends on the culture in which we live, as well as the individual personality of the person. We can usually cope with our own aging if the world in which we live does not make the fact that we are growing older a personal problem. Our society has yet to accept old women as individuals. For the most part, we are treated as members of a category and as a consequence feel powerless as individuals. Earlier I said, "Let me be a person, do not categorize me, don't define me by stereotypes." The insulting thing about stereotypes is that it is two-dimensional. And older women are not two-dimensional beings.

I think about Ruth and Naomi in the Old Testament because I loved Ruth's speech to her mother-in-law, which began, "Entreat me not to leave thee." I want to say, "And entreat me not to fit your stereotypes," which are usually negative, occasionally positive. Even the positive ones aren't doing us any service. Pollyanna, after all, is as much a pain in the neck as is the Wicked Witch of the West. It is impossible, as well as unnecessary, to smile like Pollyanna throughout one's old age, unless it is to laugh at the cosmic joke that having achieved the success we worked for—increased longevity—we decry and depreciate its results—the old. Most old women don't expect rose gardens in old age, but they shouldn't have to accept the fertilizer either.

What is bad is societal expectations and definitions of all old women. The negative perceptions and definitions of all old women. The negative perceptions and definitions virtually permeate every institutional area of our lives with severe consequences for individual older women. Unless we remedy this by our actions, we are communicating the thought and feeling that it's fine to have women around as long as they're young, skinny, and beautiful. But don't be too obvious in old age.

Let me be what I am. Being an old woman is not in and of itself an unpleasant situation. How I am stereotyped as an old woman is bad. But inaction in remedying the problems of stereotyping, it seems to me, is worse.

I called one of my colleagues on the east coast once when we were going to do some research about older women. And I said, "If you had your choice, what would be the major area in which you would do your research?" She said, "Come off it, Millie, doing more research is a cop out. We know enough now to be able to remedy some of the problems that old women are having." Let's continue doing research, but not let it be a curtain against taking action. [Applause.]

Senator GLENN. Thank you, Doctor. I think the audience response tells you what they think of it. I would only add one thing. You talk about running for public office at an old age. Might I invite you to move to Indiana, if you are thinking about running for the Senate. [Laughter.]

I know Congresswoman Oakar does have to leave and get up to Cleveland for some other meetings this afternoon. And for those of you who came in late, let me just say about her again, she does such an excellent job in the House of Representatives, and she's headed up the committees over there, and she's chairperson of the Task Force on Social Security and Women of the House Select Committee on Aging. She is truly one of our leaders in looking into this area in the Congress, has done tremendous work, and so we are honored that she has joined us here today because she was up very, very late last night in Louisville, got up very, very early this morning, so it was a short night for her just to be with us today to participate in this.

And Mary Rose, we appreciate very much you making that effort. I know you do have time constraints, so we will let you start off with the questioning.

Congresswoman OAKAR. Thank you, Senator.

I think we all owe you a debt of gratitude for your interest in this subject. I think it's important that everybody acknowledge your chairmanship, as well. I sure do.

Dr. Seltzer, I think I should have taken your course. I have a neice at Miami U, and I'm going to tell her to look you up, because I just think you are fabulous. And I hope that educational institution, along with others, does not force retirement when you reach a certain age. I am very opposed to mandatory retirement, and I'm a former professor, myself, and obviously we wish you well.

I was very interested in the themes that we had today. That was so fascinating. I think the panelists, John, that you've had testify, along with your great staff, are among the best that I've heard. The grandmother and the mother and the daughter gave an oral history of what has happened to women through varieties of generations.

Interestingly enough, the goals were very similar. All of you want economic security, and you still want to have your family and take care of your children.

Dolores, you mentioned that you still concern yourself with the fact that you could lose everything if you had to go into a nursing home, providing you really needed that care. It's true because we've almost made quality nursing home costs prohibitive. Medicare doesn't even cover it, and you have to be downright poor to get any kind of coverage.

That is a serious concern. You mentioned, as did Dr. Seltzer, the concern about the poorest of the poor. You mentioned that you did housework for other people as one of your jobs to survive.

And Doctor, you mentioned that so many black women are among the poorest.

Interestingly enough, you were lucky, Dolores, because you did pay into the system in other jobs that you were able to get. But, 95 out of 100 Americans covered by Social Security have the potential to be covered, but the 5 percent who aren't, are mostly black women who work as domestics. That is one of the saddest things that we have allowed to continue. And it is really one of the things we have to address.

You also touched on the subject that we need to address in a very comprehensive fashion, and that is the alcoholism among the

elderly. Very often that is a newly acquired problem that people get in their older years because they are lonely, or frustrated.

Marjorie, you addressed so many things, and I can't help reminding myself that I sat at the debate last night hearing that we haven't cut Social Security in 4 years. That simply is not true. You have to think that some people have fallen off a Christmas tree or something. You mentioned your husband was not eligible for the benefits because of cuts in Social Security, despite the fact he worked two jobs. I happen to believe if you pay into two systems, you should get what you paid. But most of those who would have been eligible for minimum benefits were dropped from the rolls. The majority of those affected were women between 75 and 90. The cruelest thing Government could have done was to cut that kind of a benefit. It was part of $19 billion of Social Security cuts that we've had in the last 3 years. You also mentioned the offset provision, as did your daughter.

And John, I can't help putting in a couple of plugs for a couple of pieces of legislation that I've introduced because we need your help. The only way we get things passed is with the people's lobby and holding forums like the Senator is providing. We do have a bill, H.R. 2740 on the House side, I know there is a companion bill on the Senate side to eliminate the Government pension offset.

It's grossly unfair that you are penalized for being eligible for a private and public pension. And we also have H.R. 2742 that Dr. Butler mentioned. It's an earnings sharings approach to make Social Security fair for all people in this country.

I was just struck by the similarity, and yet the evolution of what we've experienced. Sometimes, it's really important that we stand back and take a look at what we've done and the improvements we've made. Obviously, Jeryl, you had more options than your mother or your grandmother, and yet you all share the same values and similar concerns.

It has been just a beautiful presentation, Senator. And, Dr. Seltzer just put the frosting on the cake. I just can't tell you how much I appreciate being here, and being asked to join you, Senator. I look forward to your leadership on these issues. Your force in the Senate has been important to Ohioans. We are real lucky to have a Senator that cares about the people. Sometimes, they accuse the Senate, you know, of being elitist, interested only in international affairs, and that they don't get into the domestic areas as well. Our Senator does both, and does them both so well. [Applause.]

Thank you very much. I will read the rest of the testimony. Unfortunately, I have to drive back to Cleveland now.

Senator GLENN. And I'm not even up again for 2 years.

Congresswoman OAKAR. Well, I think if you had been the Presidential nominee, Dr. Seltzer would have been a great Vice President. [Applause.]

Senator GLENN. That guarantees she won't run for the Senate in Ohio, won't it.

Mary Rose, thank you very much for being with us today. I know you have to go, and we appreciate you making the effort to be here.

Dr. Seltzer, I'd like to ask, you've heard the testimony of the other women, and I'm sure some of your studies have shown this generational change and attitude and what is expected and respon-

sibilities, and it is not all without some problem areas because as a mother and a homemaker, Mrs. North has a different set of values in looking at these things than did her mother and her grandmother, and it's causing great problems.

At the same time, you then wind up with all these differences as far as spousal rights, and who does what with regard to pensions, and so on. Would you make some comments in that area? I'd appreciate your—where do we go with this?

Is it more of a Government responsibility? Is it more of a family responsibility? They are all three here in fairly close proximity to each other as far as their homes, their residences go now. That, perhaps, is almost becoming unusual instead of common. Perhaps while their testimony was excellent, maybe their situation is not exactly typical of what we see with so many families.

Dr. SELTZER. I think one of the first that came out loud and clear is that this is a family, that they share in, and are concerned with one another here, and that their values are essentially the same. I think if you look at research findings, you find that from generation to generation, some values are shared and similar within any given family. The research also shows that American adult children expect to look after their parents if their parents need it, and the parents expect them to look after them if they need help.

The American family, I keep saying everywhere, is alive and well in the United States. I don't want to disagree with you, but the mobility pattern that you talked about, one in five families moving, is really confined to a fairly small portion of the population who move frequently rather than the general population; that for families where there are old people, at least one child lives within an hour's distance of that old person. That's part of the picture.

Another part is that we do reach out and touch someone by phone. A lot of family relationships, when members are scattered around the country, involve telephoning. And, with plane transportation, in case of emergencies, we manage somehow to mobilize the money to go and look after people.

We care for our old. The old we don't care for are the people who have no families, who are alone in old age. They have never married, they have no children, or there is no money. If there is no money, it is very hard to care for old people. I think that's another part of it.

The problem that worries me is what happens when you have children who are, themselves, in their sixties and seventies, whose parents are in their eighties and nineties. These children are facing some of their own problems or transitions of old age, or of retirement, frequently of widowhood. At the same time, they are facing responsibility for their very frail elderly parents—a population that is growing. It seems to me that these kinds of new situations ought to be a very major concern to focus on.

I don't know if I answered you.

Senator GLENN. That's a good statement. That's fine.

There is another area, too, that I'd like to examine. It is the contrast of those who are out in the job market and trying, as Mrs. North is, to do, in effect, two jobs at once; be a homemaker and have a job. And I have thought sometimes that we almost ought to

be encouraging a lot of women to do that most important of all job, that one in the home.

And I know my wife, Annie, who is here, raised two kids and was a homemaker, and I think her job was every bit as difficult as any job that I had because she was a planner, an accountant, a psychologist, a doctor, whatever, in trying to run a home, which is a tremendous job in its own right. And I get the feeling sometimes that a lot of the younger women today think they are almost being disloyal to their gender unless they are out of the home and doing some other job, even though the job in the home is a full-time job, for those who can do it and don't have to move out, for financial reasons, to do other things in addition to that. I don't know whether pressures are in that direction.

You see some of the differences in the generation gap here, though, in that regard, where you see a natural move out of the home. Perhaps it's mainly a financial push. Most women might prefer to stay home and take care of the kids, but just can't do it because of financial reasons. What do you find in that regard?

Dr. SELTZER. If the women's movement means anything at all to me, it means that the women should have the option to make the choices they want, whether it is to stay at home, or whether it is to work, or whether it is to try to combine both things. I have a great deal of respect for any woman's choice, as long as it is her choice, made with full awareness of some of the consequences of that choice.

Senator GLENN. What are the differences, though, as far as financial well-being later on? Women who are in the home don't have a retirement program unless it's a Keogh, IRA, or something like that. And so there is a whole different thing of financial security that perhaps does not accrue to a homemaker that accrues to a woman who is out in professional life.

Dr. SELTZER. It would be nice if we could provide some sort of Social Security for women who remain home so that they would be eligible in terms of their own work. Certainly, their contribution to the gross national product, as well as their immediate contribution to their families, is of inestimable worth.

Mrs. NORTH. I want to stay home. I really want to stay home. I find if I add up the bills that I have to pay, there is no way that I can stay home right now. We're doing fairly well because I make the same amount as my husband and actually we have extra money. I work part time, and I find that for professional people they cannot go down to 8 or 16 hours a week. A lot of nonprofessional jobs you can get, maybe work on the weekend, work 8 hours or so.

But as a professional, it is very hard to only work 8 or 16 hours a day. You have the pressure—oh, a week. A week. That's true. There is big pressure on you to work almost at the 40 hours. Although I was taken down to part time, there were times when I had to work 40 hours because of mandatory overtime. And I find that for people who are in professional careers it is very hard to get down to the hours that you would like. And in my job, I wouldn't expect them to have like flex time, or be able to work at home. My job is just not conducive to that.

Dr. BUTLER. I was just thinking in the best sense, this hearing has been educational. A lot of what we are trying to do, it seems to me, is to better educate ourselves as to this extraordinary change that is occurring in our society. I really wish we had national study groups that would be modeled after hearings where we hear families like we heard today, share the experience of three generations, where all of us would know about the earnings sharings bill that Congresswoman Oakar pointed out, for example, that tries to treat the marital unit as an economic partnership in order to protect her Social Security.

We can learn from other countries. France, for example, does have a means by which the work at home of the housewife is treated in a dignified and financial way, appropriately as is work away from home. So there are solutions that could be reached. This political campaign, to my mind, only became, in terms of these last couple of months, an educational opportunity last night, in terms of recognizing the extent to which the stakes are extraordinarily high. The landmark legislation of this century, which is Social Security and Medicare are under great jeopardy, it seems to me, in this particular campaign. Yet how many people have said what you said in your opening remarks about your dependence upon Social Security, and the fears that are associated with the possibility of it disappearing.

I want to ask a couple of practical questions. In Ohio, what are the nursing home costs for a year? That's one of the greatest fears people have. What is going to happen if they have to go to a nursing home. What does it cost in the State of Ohio to have nursing home care?

Dr. SELTZER. Nearly $1,700 a month; $1,200 to $1,500 mostly.

Dr. BUTLER. So that's about $26,000 a year; which is below the national average, actually. It runs between $30,000 and $36,000 nationally.

How do you support that in the State of Ohio? Dr. Seltzer, how do people deal with that problem here?

Dr. SELTZER. A lot of people just spend down until they are eligible for Medicaid, which seems very destructive for individuals, because we are saying, in effect, "You have worked all of your life, you've saved your money, you've done all the right things. Now, what you have to do is give up all this money so that you can be eligible for public assistance and Medicaid." And this prospect is terrifying. It is one of the things that scares us about being old.

Dr. BUTLER. In the State of Ohio, do you feel Government has been as attentive to older women as it could be?

Dr. SELTZER. I think there has been an increase in this attentiveness in the past months and this year. And I think evidence of it is the number of older women who are here, many of whom undoubtedly associated with some of the organizations of older women.

Dr. BUTLER. Do you think it would be useful if there were, say, small workshops, retreats of editors and publishers of Ohio newspapers to really get good background on the realities of the aging society and the position of women in that aging society?

Dr. SELTZER. It would be marvelous. It would be very supportive. I'm sure that most of the women here would be very supportive, and most of the men too, because the problems of old women are

closely related in many instances to the problems of old men. Old men are also worried about Medicare, Medicaid, about spending down, and about what happens to their wives and widows if they—the husbands—end up in nursing homes.

Dr. BUTLER. You see, I often think that people in education and publishing are so busy, and are so caught up in the moment-to-moment issues, they don't really have a chance to sit and listen to a panel such as we've just heard where they get a whole sense of the generational development, the common values that have been identified, and to really know what the concerns of people are. Like being able to pay for that nursing home, or better, how to avoid going to a nursing home. I just wondered if this unique hearing today could become a kind of model for an educational effort in one State, the State of Ohio, almost on a circuit ride, to see if other parts of the State, and editors and publishers in this State, could really have at least a half a day to think about something that they probably haven't had a chance to give more than 10 minutes' thought to.

Dr. SELTZER. It will be a very important and very helpful kind of activity for us to engage in.

Senator GLENN. We will have the Governor here this afternoon. Perhaps we can bounce that one off of him.

I'm sure he has someone here monitoring what is going on this morning. Perhaps that's one you will want this afternoon.

One of the difficulties with women in the elderly ranks, too, is what you brought up about pensions. In other words, the widow's blackout, pensions dying with the husband, where we don't have pensions that go over and cover the wife, also. And that's a difficult thing. And we've passed this Retirement Equity Act in the Congress, and it includes the provision requiring both spouses to be notified of a waiver in survivor benefits. But that doesn't cover the whole thing. That's just a little first step in it. But I think what you point out with the difficulty with pensions, and I think is a very real thing that we have to address, we are already taking that first little nibbling step on it. But it is just a first little step as I see it.

But I think what we need to get into is the idea that whether you are a homemaker, only out in the work force part-time, full-time, whatever, that earnings of the family—that the earnings sharing provisions that we have proposed and talked a lot about, I think we have to put those into law one of these days, and I think that would be a step in the right direction.

Dr. BUTLER. It occurs to me to mention a response to your very appropriate criticism of doctor attitudes. We are fortunately seeing more and more women in medical schools. And I think nationally now something like 25 percent of all medical students are women. I know in our medical school in this year's class it was close to 40 percent. Clearly, it should be about 52 percent. But that is an important change.

I also think that when the Governor is here this afternoon, the fact that Ohio has been in the forefront of providing funds in medical education, in relationship to geriatrics, might be further explored and deepened, around this issue of attitudes and around adequate teaching. For example, very few American medical

schools rotate students through a nursing home. And yet, as we mentioned earlier, on any given day there are more women in nursing homes than hospitals. Yet how many students get a sense of the different rhythm, the different tempo, the different type of care that has to be provided in a home for the aging, or a nursing home, compared to an acute high technology hospital, which is a very different flavor and requires a very different attitude and a very different set of approaches by the physician.

Dr. SELTZER. I would just like to pick that up in two ways. One is that the presence of women in medical schools will not make a difference unless the training to which they are exposed is different. And the second thing I would like to pick up and build on is something both of you mentioned earlier today, which is an emphasis on preventing problems rather than on therapeutic solutions, once a problem has been exacerbated beyond belief. If somehow we could get across the idea that we should be preventing the occurrences of illness and preventing poor health through a variety of sources, not only would medical costs be reduced, but there would also begin to be a change in our attitudes toward people.

Dr. BUTLER. My own sense is that prevention cannot only be seen as medical; for example, a broken hip. By walking into a home of an older person, one can see if there are toe-catching rugs and if the safety of the kitchen, bathroom, and bedroom needs to be adequately reviewed and resecured in terms of safety. So there are a lot of social and nursing and strictly nonmedical aspects of prevention that have to be looked to. I am not quite as pessimistic as you are about women in medical schools. I think it has already made a difference.

I am struck by the fact that half of our department faculty is women, and that the types of issues which the women in the medical frame are addressing are very extensive. Now, there are great needs for reforms in medical school. I completely agree with you on that. But I don't think we should sell women short. They are already beginning to have an effect, themselves, within the medical school.

Dr. SELTZER. I would never sell women short. I wouldn't sell men short either, frankly. What I'm saying is that it's the nature of the medical training that concerns me. I think you are quite right that prevention takes place in many arenas and at many levels, and this should be our broad concern.

Senator GLENN. Let me have just a few more questions and we will break here until the afternoon session.

Mrs. Snyder, you're in a position where you're in the apartment complex where you live, it's operated by the national church residences. Although you said you do not require social services, if you do need them, are the things such as meals available there and supportive services and nursing care and transportation services for those residents who need help?

Mrs. SNYDER. No.

Senator GLENN. None of those facilities are available?

Mrs. SNYDER. No.

Senator GLENN. I don't want to raise something that might be unpleasant for you, but if you get to a point where you might need

some of those services, will you tell us, would you share with us what your plans or thoughts are in that area?

Mrs. SNYDER. Well, I really don't know. I depend on my daughter to help.

Mrs. JENKS. Yes; I think that is really a question more for me perhaps than for her.

I don't know. I think I'm probably facing what a lot of younger women are going to face sometime. I like my job. I want to continue to work. I do realize that, you know, should my husband become ill, should my mother become ill, I would probably quit working, and stay home. And knowing that I probably, at this age, would not become employed again, that would be it. So the choice would really be mine.

Senator GLENN. The problem that points up, though, is what happens if they do not have a daughter nearby?

Mrs. JENKS. Yes.

Senator GLENN. And do not have somebody to take care of them.

Mrs. JENKS. I thought as an only child, if something happened to me, my mother would really be alone.

Senator GLENN. And from outward appearance you all appear to be in good health.

Mrs. JENKS. Yes, a great deal of what has happened in our lives, we've been very lucky because someplace along the line, if one of our husbands had had serious medical problems we would not be able to work.

Senator GLENN. There would not be a family member to take care of the elderly.

Mrs. JENKS. Yes.

Senator GLENN. Mrs. Snyder, you also mentioned your husband was retired from a job just a few months before becoming vested for a pension.

Mrs. JENKS. Is that now illegal? Can you just let someone go just a few months' short?

Senator GLENN. There is not a law. I think you have a certain vesting period in most pension plans. I don't think there is any law that says if you are a few months' short. I consider it unethical and immoral, but I don't think——

Mrs. JENKS. It's not illegal?

Senator GLENN. There is no law that says no, that you have to keep a person employed. That's a difficult area to get into, also, of course.

Mrs. Jenks, when you wanted to go back and be retrained, were there adequate retraining facilities available if you wanted to use them?

In other words, we, in Ohio, take great pride in the fact that we have quite a community college system, and that we have an extension service system out of the State universities. And were these adequate for whatever purposes you needed?

Mrs. JENKS. I used the adult day school at the high school near me and went back and took up brush-up courses there. They could offer what I needed.

Senator GLENN. That was adequate. And most people that you know that were in your similar situation, did they have other training facilities?

Mrs. JENKS. In the class I was in, there was a number of women my age who were doing the same thing, were going back to work, were brushing up on skills they had had before, and it was fairly inexpensive.

Senator GLENN. Most of them were not changing the whole direction of vocational training?

Mrs. JENKS. No; just brushing up on skills.

I often thought the very fact that I worked until I was 27—I didn't realize, at the time—gave me a base to go back to. Had I quit at 21 and had children, I would have had nothing to go back to, and I imagine I would have ended up clerking in a store, or something, because I would have had no base to build on. But I did have something that I could go back and build on.

Senator GLENN. You've looked at this system, though. Do you think we have a pretty good system in Ohio, or do we need to work to improve that system as far as availability of training for people?

Mrs. JENKS. I really don't know what all is available. I would imagine that through night schools and probably at the college, that there are training things you can find, if you—I don't know if women would have problems affording them. Some of them probably would. But I didn't find any problem.

Senator GLENN. Dr. Seltzer, you've probably looked into that. What do you think? What is our status in Ohio? Do we need programs in that particular area, not just educational, but from the standpoint of retraining?

Dr. SELTZER. Despite the presence of community colleges and colleges in high schools, a lot of people: First, don't know about the programs; second, can't get to them; and third, frequently meet teachers in these programs that are less than enthusiastic about older students, so that we could probably do some improvement on our conditions.

Senator GLENN. Mrs. North, you've talked about—let me preface this by saying in my own traveling, not only in Ohio but the country, I find that a lot of our young people's attitude toward Social Security is quite disturbing. A lot of them don't think they will ever receive it. Quite a bit of them are taking alternative measures to provide for their retirement. You touched on that same thing in your statement. So you see this as a person out there working in this field, what do you think we can do to improve public perception among young people of the Social Security System and of its reliability?

You obviously have some doubts about it, yourself.

Mrs. NORTH. And you are right. And it's hard to justify it many times.

As Representative Oakar said, Bill 2740, supporting that. I think if things like that are passed, people will get some security that things are not always being taken away. That will put some security back in people's minds.

Also, we have a lot of problems that everything negative about Social Security is in the papers.

Senator GLENN. On the front page of Newsweek, as Dr. Butler says.

Mrs. NORTH. It's upsetting to the people who work for Social Security, but also for everybody who plans on someday to draw it. We

have people at work that go through the papers daily to look at what is being said, because a lot of people come in and they have read the article. I won't say things are lies, but a lot of things misleading make Social Security look bad.

There are a lot of good things about Social Security, but they are never brought out. I thought Social Security needs a good PR job. Because there are a lot of things about Social Security, and one of the problems I think when I started for Social Security, I knew nothing about what the minimum was, what the maximum was, how long you had to work. I mean nothing. I would say that most people, I wouldn't say the percentage, but maybe 90, 95 percent have no idea what they are going to draw, what amount they are going to draw, what their spouse is going to draw. I think public service announcements on TV, the only thing I see from Social Security is for women to change their name when they get married.

That's very unimportant. If you have your Social Security number, you don't really need to change your name. It might help with record keeping. That is not important. What is important is how much they are going to draw, and how much they are going to be able to draw, and I think that ought to be emphasized in the media; that Social Security should take time on radio, newspaper, TV, to let people know what to expect. Because we have a lot of people who come in and say, "I can't live on Social Security."

You have to tell them it wasn't meant to be your only income. They say nobody ever told them that. And nobody ever told them that because Social Security did not make announcements to them that that was supposed to be just a base to supplement other income.

Dr. BUTLER. I think an emphasis on Social Security's part of that public relations campaign is, as you suggest, that we recognize that Social Security is not only a pension system for older people. It's much more. It's equal to, say, for a 29-year old, a quarter of a million dollars' worth of life insurance. If something happens to him or her at 29, one's child, one's spouse will have some protection because of the death of the breadwinner, or if he or she becomes disabled as a worker. So I think I see it responding to vicissitudes of life that anyone of us could face, unfortunately, in a particular moment.

The second point I'd like to make, in relationship to Social Security is a better "selling" job, as you put it, is to demonstrate that there are more transfers of income and assets from older people to younger people than younger people to older people. If you read the standard story about Social Security, you would think that younger people are being ripped off in favor of older people, with emphasis upon all these income transfers that Social Security from the working generation to the older generation.

But that only looks at one sector, namely Social Security, and it doesn't look at the exchange of goods and services and funds and income from old to young.

And my last point while we are defending Government here for a minute, in the private sector, if you look at those Blue Cross forms and other private insurance forms, they are just as complicated as the Medicare form.

Senator GLENN. Good point.

Jeryl, you're in a different situation than either your mother or grandmother has been. You're out in the work force. You have a family at home. You have some conflicts in your own mind about some of these things. From a very practical standpoint, how do you break down family responsibilities? Does your husband take some of the responsibilities at home taking care of the kids and doing some of the chores around the house, or—I'm going to get in deep trouble here.

Mrs. NORTH. Thank God, my husband is not here.

Senator GLENN. I'm going to send him a transcript of the hearing.

Is this making a whole different type lifestyle than your mother or grandmother? Is it bad, good or indifferent, does it make a sharing—a closer relationship, or is it a strain?

Mrs. NORTH. I can't say if it's better or worse. I mean that is all I've known. My husband is a teacher. Last summer, this past summer, he stayed home with the child and babysat. If you saw the movie "Mr. Mom," he said at the end he felt his brains were oatmeal.

We always thought—we discussed alternatives, at one time.

He said, "Why can't I stay home?"

After the summer, he decided that there was no way that he wanted to stay home with our 16-month old son. It was too much work. Finally, for the first time in 8 years, he was glad to go back to school teaching. Every year before, "I've got 2 more weeks."

He gets off at 2:30. I get off work 4:30. When I come home, he usually has supper fixed, and I don't have to do that. He does his own laundry. I do my laundry. Sometimes he does some extra things around the household. His mother did not teach him what had to be done, like cleaning the bathtub. His mother taught my husband's sister to do that.

He knows you have to eat. That is important. But he's not real independent in doing the dishes. He knows he has to wash clothes.

He does do some of the work. I wish he would do more. But he's a lot better than a lot of husbands I've seen sharing.

Senator GLENN. Well, I think it's obvious some of the changing relationships that we are running into now are causing problems. He's finding out, too, that housework, or homework, is work. The work part of it is real.

We joke a lot, and we see the cartoons all the time about women sitting around watching the soaps all day at home on TV, but housework, homework is work. And it's just as much a full-time job as any other. Where you're out in the workplace, then you do have to share a lot.

I think one thing that was pointed out a little while ago, her difficulty understanding some of the Social Security forms for a very complex law. As Dr. Butler pointed out, lifelong—it's not just when you retire that you have some Social Security benefits. If there are certain things that occur within the family, disabilities, and so on. And many people, too many people, are not aware of some of these things that they might be eligible for. And I'm sure you deal with that in your job every single day. That's what you are doing.

Yet, sometimes if you go to Social Security and get their description of what rights are available to everyone, we've had complaints

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that these are, once again, placed too often in bureaucratic language that are very difficult to understand. The committee has talked in the past about maybe trying to put out our own publications from the committee on aging that would be written in layman's language so people could understand these things.

We haven't moved ahead with that, partly, I guess, because we don't have the staff size that might be required to do some of that work. But, and I'm not sure whether it can be done or not, quite honestly. Can you take a law this complex and try to put them into layman's language so people really understand them, and understand what their rights are. I am sure we can do a better job than a lot of publications out there. Maybe we need something in that area. Would that help?

Mrs. NORTH. I will tell you, it's hard for us to understand the law and we work there. When a new law comes out, we usually get a teletype explaining it. And sometimes because of the legalities, we are not sure what the law means. And it is very discouraging to us because people are coming in to ask us and we are not even sure what it means.

Eventually we have clarification, but when something comes up about pension offsets, people are very interested, and we have a lot of phone calls, and we are not sure because we don't know. We don't—we aren't—we often say in our job we have to be an a'torney, we have to be accountants, we have to have so many specializations. And we can't have all this training. We get things often very baffled.

Senator GLENN. Dr. Butler, is there any way other nations take care of this? Do they understand them better; write better laws?

Dr. BUTLER. I don't know. It, again, brings me back to this complaint about publishers and editors, TV, considering what a landmark, vital importance our own personal security, and that of our family's is. If we really mean it when we talk about the importance of the American family, surely we can figure out more effective ways of presenting Social Security than we presently do. I'm convinced it's doable. It might be hard, but I certainly think it is doable.

Senator GLENN. I agree very much with the remarks Mary Rose Oakar made about what great witnesses we've had here today. Many people have helped out on this hearing. We are going to have our break here in just a few moments. I know you get in trouble when you start singling out people very much. But I do want to thank Brenda Spradling, under the leadership of Joyce Chapple, who arranged for the three-generation appearance today, along with Dr. Seltzer. And I again thank all of you, and the panel, too, here. And I appreciate all of you coming out on a holiday such as this. Maybe that is one reason why we had so many people, because it is a holiday.

In quite a different vein than the hearing that we are on this morning, and knowing that everything does fall around money with the Federal Government, I thought perhaps a little story about why we feel such kinship with Christopher Columbus at the Federal level might be in order. Because we have a national holiday that celebrates Christopher Columbus, Columbus Day. And I think there is a reason why we have declared it a national holiday

in Washington, and we at the Federal level give it such credibility and notice, and all Federal offices are closed on Columbus Day.

The story goes, we feel that kinship because Columbus didn't know where he was going when he started, he didn't know where he was when he got there, and he did the whole thing on borrowed money. [Laughter and applause.]

What that means to today's hearing, I don't have the foggiest idea. But I like the story anyway.

We will take a break until 2 o'clock. We will have the Governor and other panelists this afternoon. I hope you all can stay.

Thanks to all our panelists. Let's give them a big hand. [Applause.]

[Whereupon the hearing was recessed until 2 p.m.]

AFTER RECESS

Senator GLENN. The hearing will please be in order.

Thank you very much. I'm glad to see so many people here this afternoon. We had an excellent and very productive session this morning, as I'm sure most of you would agree, or all of you would agree. And it is a real pleasure to be here chairing a hearing such as this with the Special Committee on Aging. We try to have as many field hearings as we can every year so we get views from all over the country.

I've asked Dr. Seltzer, who most of you heard this morning give such an outstanding presentation, to join me in questioning our panel this afternoon.

Before I get to that, we have another witness here who is going to be with us for an hour or so. I've asked him not only to present some material this afternoon on the situation in Ohio, but also to join us on the panel for as long as he can stay.

I'm especially pleased that we have Governor Celeste with us here today. During his career as a State legislator and as Governor, Dick has been a very strong advocate for older Ohioans. And in that I mean not just by a legislative record, but from being with him when there were concerns about the elderly being expressed, and I know firsthand on a personal basis, his particular interest in the problems of the elderly. In fact, last spring he recommended legislation which was passed to elevate the Ohio Commission on Aging to departmental status. And so now the 1.2 million older citizens in Ohio have a representative at the Governor's cabinet meetings, not just a commission or a board, but it is now a part of the regular cabinet system in Ohio, and that's the kind of attention that Governor Celeste has given to this. We will have Joyce Chapple, as part of our panel here a little bit later on today, who is the director of that department. But it gives me a particular pleasure to introduce a personal friend, and the Governor of the State of Ohio, for his statement, Gov. Dick Celeste. [Applause.]

STATEMENT OF HON. RICHARD F. CELESTE, GOVERNOR, STATE OF OHIO

Governor CELESTE. Thank you very much.

I want to express my unbiased appreciation of the fact that our senior Senator from Ohio has chosen to have a meeting of the U.S.

Senate Special Committee on Aging here in Columbus, OH, the heart of it all, Senator. We're proud to welcome you here for this. [Applause.]

And to Dr. Seltzer, and to all the others who are here, I understand the discussion this morning was an excellent one, and I think it's really a tribute to the esteem in which we all hold you, Senator Glenn, for your leadership, and for your interest in this vital subject, as we focus on women in our aging society.

Let me also acknowledge the presence of the director of our department of aging, who has just joined us, Joyce Chapple, who is doing an outstanding job, another unbiased observation, an outstanding job as the director of the Department of Aging. [Applause.]

Ohio has more than 5.6 million women, more than half of all of our citizens are women, over 700,000 of these women are over 65 years of age. Today over half of the working-age women are active and vital part of Ohio's work force, a far cry from 1950 when less than 30 percent of our women participated in the work force.

The number of women in the work force in Ohio and nationwide will continue to grow well into the 1990's. By 1995 we expect nearly 60 percent of the women between the age of 35 and 44 to be in the work force. And the fastest growing segment of our Nation's work force will be comprised of women over the age of 40.

Last month, we held our seventh annual induction into Ohio's Women's Hall of Fame in order to recognize leaders among Ohio's women. In the past, each of the past 2 years, fully a third of the inductees were older women. Last year we placed, we honored three outstanding Ohio women by placing them into the Senior Citizens Hall of Fame.

Ohio, like the rest of the Nation, is growing older. Persons over 65 and to an even greater extent, persons over 75, are growing in number faster than any other group in our population. For the first time in our history, older persons outnumber teenagers. And to emphasize the importance of this topic, 61 percent of our older Ohioans are women.

When we look closely at this trend, it is obvious that we must pay particularly close attention to older women. Two out of every three persons in Ohio over the age of 75 are women. It is this age group that is most likely to suffer disabling chronic illness requiring long-term care.

Older women, more frequently than older men, live on substandard poverty incomes and live alone. In the last 15 years the number of older women living alone has doubled. Combined, these factors constitute the greatest threat to the independence and well-being of older women.

Older women suffer double and even triple jeopardy from poverty, from illness, and all too frequently, from isolation. While we cannot prevent aging as a matter of public policy, or even as a matter of personal preference, we can certainly go a long way in preventing the kind of isolation which can be life threatening or debilitating.

Only a few days ago I heard a story recounted by a Meals-on-Wheels provider here in Central Ohio about an older woman who lived alone in a deteriorating inner-city neighborhood. This woman

received the daily meal delivered to her home. When the driver arrived he rang the doorbell. This woman is unable to get downstairs. So she would go over to the second-floor window, and only when she had assured herself of who it was at the door, would she throw the keys out of the window so that the driver could let himself in, bring the hot meal and the keys to her, and once the meal was delivered, he would go downstairs and lock the door behind him and leave.

I think that this story epitomizes the concern which I would like to stress. And that is that isolation, even to the point of being confined in a locked house, is a devastating reality for too many older women in our State.

In addition, if we look to long-term care, another dimension of the problems faced by older women becomes apparent. It is now generally recognized that most of our frail and chronically ill adults are cared for at home, not in institutions, but at home, most often by a spouse, a daughter, or a sister. In one situation here in Columbus, a woman was making a living providing child care in her home.

Her mother, who was a severe diabetic in her 80's, was discharged from the hospital and needed continuous supervision when she came home. Without this help, she would have been placed in a nursing home. Consequently her daughter chose to give up the child care, which was livelihood, in order to provide assistance to her mother, which was love and caring and family.

It is becoming increasingly more common to find older women suffering from multiple chronic infirmities being cared for by a daughter or a sister who is herself older and perhaps suffering from a chronic condition. One case I remember vividly, and this goes back to my first campaign for State representative, it was this season of the area, and I was knocking on doors not far from my campaign headquarters. I knocked on the door, and an older woman came to the door. I would have said that she was perhaps in her 70's. I said I was Dick Celeste, and I was running for State representative, and so on. And she turned her head to the living room, and she said, "Mother, there is a young man at the door, and he's campaigning for State representative."

I went into this living room and there was a hospital bed which had been moved to living room and a woman who was 102 years old at home with her daughter who was in her late 70's, as it turned out. And her mother was absolutely alert, but very frail. The daughter, fortunately healthy, able, still, to take care. But an example of the kind of living circumstances which may be more and more frequent, will be more and more frequent, in the years ahead.

I'm familiar with one case here in Columbus in which both the mother and daughter were receiving services from the same home care agency, while the daughter continued to try to take care of her mother's most basic needs.

In planning for the long-term care of our older Ohioans and in framing public policy, one thing is evident. We cannot make the assumption that the amount of care from home sources will remain constant in coming years. Our long-term-care dollar is going to have to care for large numbers of older women in a variety of cir-

cumstances. In this regard, we should direct our resources toward services in the home and in the community which enable people to forestall institutional care as much as possible.

Second, we must focus in our health care thinking and action, we must focus on prevention to early diagnosis and health maintenance for all ages, including older persons. And finally, we should ensure that every effort is made to work with, and support those families and friends who engage in caring for their older parents, or relatives, or neighbors. We need to find ways to find support for them.

Another vital area of concern, the last vital area of concern I would like to mention this afternoon, has to do with relating to the circumstances of older women here in Ohio, and I believe across the country, has to do with income or economic security. In 1981, the median annual income of women over 65 was $4,747. That was slightly over the poverty level, but less than 60 percent of the median income of older men; 74 percent of the older persons who receive SSI are women. Where retirement income is generally built on three bases of support, Social Security, pensions, and savings, pensions are precarious at best for many women. Time and time again we've seen situations where women enter the job market later in life, are either not eligible for company pensions, or contribute too little too late to the pension fund so that it does not offer much in return in terms of retirement income.

Poverty and isolation, alternatives to long-term care, and economic security are, in my judgment, just a few of the vital concerns confronting all of us as we shape public policy with respect to older women in our State and our Nation. I want to emphasize we are facing trends today, the magnitude of which we are only beginning to appreciate.

That is one reason why I'm so grateful for this meeting of this special subcommittee, Senator. I think it is absolutely essential, at this time, try to look down the road. As a Nation, and as a State, I believe we will be judged by how well we respond to these trends, understand them, and shape public policy which can meet the challenges they pose even when sometimes hard choices about where we put our resources are involved.

Thank you very much.

Senator GLENN. Thank you, Governor, that's excellent. [Applause.]

[The prepared statement of Governor Celeste follows:]

PREPARED STATEMENT OF GOV. RICHARD F. CELESTE

Mr. Chairman, and members of the committee, I want to welcome you to Ohio and thank you for this opportunity to testify on the topic of "Women in Our Aging Society." Let me begin by acknowledging and commending the leadership your committee has provided on behalf of senior citizens across the United States.

Ohio has over 5.6 million women, which is more than half of our citizens. Over 700,000 are over 65 years of age.

It has been clear to me, as I took office and throughout my current term, that women have played a key role in Ohio's past, and will in the present and future. They are equal partners in helping us solve problems in our communities, in our economy and in our government. Today, over half of the women of working age are in Ohio's work force—a far cry from 1950, when less than 30 percent were in the work force. Growth in the number of women in the work force will continue well into the 1990's, in both number and percentage. By 1995, we expect nearly 60 per-

cent of the women between 35 and 44 to be in the work force. Of particular note to this committee is the fact that the fastest growing segment of the Nation's work force is women over the age of 40.

In recognizing Ohio's women for their current and past contributions to the State, we have recently held our 7th annual induction into Ohio's Women's Hall of Fame. In the past 2 years, one-third of the inductees were older women. Last year, we honored three outstanding Ohio women by placing them into the Senior Citizens Hall of Fame. As you can see, our State has been fortunate in being able to draw on the talent and commitment of many women throughout the years.

Ohio, like the rest of the Nation, is also growing older. In 1980, 706,000 Ohioans fell between the ages of 65 and 74 years, while 463,000 persons were 75 years or older. Persons over 65, and to an even greater extent, persons over 75, are growing in number faster than any other group. Older persons, for the first time in our history, out number teenagers. 61 percent of our older Ohioans are women.

When we look closely at this trend, it is obvious that we must be particularly cognizant of older women. Two out of every three persons over 75 are women in Ohio. It is this age group which are more likely to suffer disabling, chronic illnesses requiring long-term care. Older women, more frequently than older men, live on substandard, poverty incomes and live alone. The number of older women living alone has doubled in the last 15 years.

Combined, these factors constitute the gravest threat to the independence and well-being of older women. In essence, they suffer double and triple jeopardy from poverty, illness and possible isolation. We cannot prevent aging, but we can go a long way in preventing the kind of isolation and frailty which are life threatening or debilitating.

Only a few days ago, I heard a story recounted by a meals-on-wheels provider in central Ohio, about an older women who lived alone in a deteriorating, innercity neighborhood. This woman received a daily hot meal delivered to her home. When the driver arrived, he rang the bell. Unable to get downstairs, this woman could only reach the second floor window. And, when she was sure who it was at the door, would throw the keys out the window and down to the driver to let him in. The driver would then leave the meal and relock the door of the house when he left.

This epitomizes the very idea I would like to stress. Isolation, even to the point of being confined to a locked house, is a devastating experience for many older women. For so many, like the woman I just spoke of, a meals-on-wheels program or a visiting senior volunteers or a telephone call to or from relatives and friends are an essential ingredient in remaining in the community. If we are to make an impact, it is imperative that we build and expand programs which will counteract loneliness and isolation. Senior volunteer programs, for instance, are an aid to older persons needing companionship and assistance. But also, they can restore a sense of worth and contribution to the older volunteer, herself. It is a two-way street. In Ohio, senior volunteers in programs such as meals-on-wheels number in the thousands, but it only scratches the surface of the need.

If we turn for a moment to long-term care, another dimension to the problems faced by older women is apparent. It is now generally recognized that most of our frail and chronically ill older adults are cared for at home, most often by a spouse, a daughter or sister. We are seeing time and time again situations where daughters will come to the aid of an older parent. In one situation, here in Columbus, a woman was making a living providing child care in her home. Her mother, who was a severe diabetic in her 80's, was discharged from the hospital and needed continuous supervision in the home. Without this help she would have been placed in a nursing home. However, the daughter gave up child care to provide assistance to her mother.

It is also getting more and more common to find an older woman, suffering from multiple chronic infirmities, to be cared for by a daughter or sister, who herself is older and suffering from a chronic condition. In one case, I am familiar with, the mother and daughter were both receiving services from the same home care agency, while the daughter continued to try and take care of her mother's most basic needs. These caring relationships are very strong and it is worth the public investment to support care provided by families, neighbors or friends.

We do not know, yet, to what extent the increased participation by women in the work force will affect these natural care systems, nor what effect changing patterns of marriage, childrearing in middle-age and single-parent households will have on the availability of daughters, spouses and siblings for providing ongoing care in the future. But we must not make the assumption that the amount of care from these sources will remain constant in the coming years.

Our long-term care dollar is going to care for older women. And, in this regard, we should, first, direct our resources toward services in the home and community which enable people to forestall institutional care. Secondly, our national agenda should also focus on prevention through early diagnosis and health maintenance for all ages, including older persons. Thirdly, efforts should be made to work with and support the family or friends who engage in caring for their older parents, relatives, or neighbors. Services such as respite care and training for caregivers are important ingredients in our efforts to provide community and home care to the frail.

Turning to economic security for older women, we should note that a number of national issues deserve attention. We believe that the issues of retirement income should be considered in the context of the economic status of older women. In fact, nationally, the median annual income of women over 65 in 1981 was $4,757, only slightly over poverty level and less than 60 percent of the median income for older men. To illustrate this further, 74 percent of the older persons who receive SSI are women. As I noted, they are much poorer, live longer, and due to difference in marital status, tend to live alone

Where retirement income is generally built on the three supports of Social Security, pensions and savings, one support--pensions—is precarious, at best for older women. We have seen time and time again the situation where women enter the job market late, are either not eligible for company pensions, or contribute so little, too late to the pension fund that it does not offer much in return in retirement income. As a Nation, we need to pursue policies which attack those factors which make older women among the most vulnerable citizens. Income is certainly a major factor in the loss of independence among older adults.

In summary, I have outlined here some critical issues which are facing the Nation in regard to women in an aging society. These are income, health care, family caregiving and isolation. We are facing problems today, the magnitude of which is only now becoming apparent. As a Nation, we are judged by how well we take hold of the problem and pursue the most promising solutions, even when hard choices need to be made.

Senator GLENN. Just to discuss your statement for a couple of minutes here, the points you make, I think, are excellent. I also have been very proud of Ohio through the years in that we have not particularly been laggard through the years compared to other States, although we don't do nearly as much as we would like to do. But with regard to the elderly and their problems and taking cognizance of them, I think perhaps we have some opportunities here in Ohio that maybe most people have not realized from a slightly different standpoint. We've had, in the past, a bipartisan interest. It hasn't just been one political party that says, yes, we should take care of our elderly. So we have had programs through the years that were ongoing programs. We expanded them some, as I mentioned in my introduction of our Governor just a few minutes ago, his latest effort in this regard.

Ohio is almost a micrographic of the whole country. And I think what will work here in Ohio will work anywhere in this country. And that is the reason why I would like to see us in the future stay in advance, stay on top of this thing, and I want to cooperate in every way possible from the Federal Government in trying to see if we can't keep Ohio as a test area in this.

For instance, we have every realm of political thought across Ohio from far liberal left to far radical right. We have every old industry, every new industry, every ethnic group who ever thought of getting to people and getting organized. We range from hard-rock hill country to some of the finest farm land in the world. We are almost as though you took the whole Nation and squeezed it down into a smaller political entity and there we sit as Ohio. So we face in this area, problems of all the different people, and I think

that what I'm saying is evidenced by the fact that Ohio is often used by major corporations as a test marketing area.

Columbus, OH, right where we are now, is used as one of the test marketing areas for the whole country. Corporations come in and test market new products and things, because we are, we can give them an idea of what is going to happen across this whole Nation of ours if they are successful or unsuccessful with test marketing right here. So I think in this area dealing with the elderly, and Ohio having been one of the States that has been traditionally forward looking in this regard, we want to be as active as we can in furthering programs that perhaps can be put into place on a wider basis all across this Nation.

Now, pursuant to that, I would like to ask your opinion, Governor, on what we best can do as far as setting up a ratio of support. Does the State look to the Federal Government for the studies and the background and the data base that we need to address this; are you doing that here on your own? You are a member of the National Governors' Conference, and I'm sure you've talked about some of these matters there. What can we do at the Federal level that would best help?

I know that the obvious first and immediate answer is to send money. It's not just all sending money. It's the programs and finding out what will work. You mention the Meals on Wheels, the isolation of people. Cleveland has been active on some of the national projects, congregate housing, and things like that, where we bring help to bear in communities rather than seeing people institutionalized. We don't have institutions to take all the people that would be required to have help if we tried to do that.

Do you have any suggestions you can give us in particular areas where we can be particularly helpful to the State of Ohio from the Federal Government.

Governor CELESTE. I'm glad you asked me that question, Senator. I have several ideas.

Let me underscore your point, however, about Ohio is leader and Ohio as a resource for showing the way. I know because it's where I learned about the problems of senior citizens first. Ohio was the site of the first 202 housing project, direct loan housing project for senior citizens anywhere this side of the Mississippi. It was the Warton Center in Lakewood, OH, old coal yard converted for housing for senior citizens, and that project has since expanded three times.

I think it's fair to say that Ohio is probably one of two or three States leading the country in the development of that kind of housing for senior citizens. We demonstrated that it would work. And I'm sure there are other ways the gerontology program at Miami University is one of the two or three best in the country, in my judgment. And that gives me one thought about a place where we can, consistent with another of your interests, Senator Glenn, where we can be very aggressive. That is the whole field of aging is a place where we should be investing substantial human experience oriented research and development dollars. These are research and development dollars that have to do with the whole range of the dimensions of problems of aging. And that includes, as they relate to physical health of older people, as it relates to the

impact of family units, things of this kind. I think it's never gotten our fair share of R&D dollars. That is a place where you're leading a fight. And I would encourage us to think in terms of R&D dollars coming into this State through institutions like Miami.

Another aspect of Federal policy which I think can be very helpful to us, and I think Director Chapple might want to expand on this in her comments, has to do with the flexibility that we need within Federal programs to look at alternatives. Can we use dollars that would, a portion of which would be only a small portion of what we would be paying for Medicaid in an institution for health services based in the home. For alternatives that aren't delivered within an accredited Medicare Medicaid institution.

We need the flexibility to be able to provide those kinds of home based or community based services to help, to insure alternatives to institutional care. I think frequently we end up spending more dollars of Federal money when we can only do it through certain institutions. And we would be spending, if that same overall dollar resource were available for less expensive, maybe better in human terms, and more effective home base or community based care. So flexibility in the programs, I think is important.

Obviously there are places where dollars are vital and we should not lose sight of that. Although I think we are finding in terms of our experience, for example with Medicaid at the State level, that it is possible to begin to constrain costs without denying people access to essential services. And the challenge there both at the Federal and State level seems to me is to look for ways to balance our need to get a handled on skyrocketing costs, and at the same time maintain essential services for people.

Senator GLENN. Good. Dr. Seltzer, do you have any comments on this?

Dr. SELTZER. While I'm absolutely delighted to hear about Miami, I think it is good also to recognize other universities in the State of Ohio who have strong gerontology programs.

Governor CELESTE. I said excellent. They weren't sitting next to me.

Dr. SELTZER. That is true, they weren't sitting next to you. But I would wonder if there would be any possibility of considering, at least, looking at, a modified Bagala bill within the State. I know this is a national hearing, but a modified Bagala bill within the State to consider funding gerontology programs.

Governor CELESTE. I think the answer is yes; in terms of consideration. Now, whether the dollars are there.

The budget process we are going through right now is going to provide us the opportunity to take a look at that.

Senator GLENN. Thank you very much. And I would ask the Governor to stay as long as he could because we want to get on with the other panel here this afternoon. And Governor, we hope you can stay with us as long as possible.

And we will go to the panel now.

And our first panelist, Dr. Robert Atchley, is the director of the master of gerontological studies degree program, and a professor of sociology and anthropology at Miami University in Oxford. He has written very extensively on issues relating to retirement income security, preretirement planning, and older women and employment.

Dr. Atchley will present us with an analysis of the economic status of women and recommendations on how we can improve it. Dr. Atchley.

STATEMENT OF DR. ROBERT C. ATCHLEY, DIRECTOR, MASTER OF GERONTOLOGICAL STUDIES DEGREE PROGRAM, DEPARTMENT OF SOCIOLOGY AND ANTHROPOLOGY, MIAMI UNIVERSITY, OXFORD, OH

Dr. ATCHLEY. What I'm going to be doing is to move away from Ohio as a specific focus of our attention for the moment. But before I do, I also would like to reiterate what everybody has said about good things going on in Ohio. I think we are well ahead of most States in the country, and I get around the country quite a bit.

I think we are doing an excellent job here. But one place where I believe that an absolute national effort and commitment are required is in marshaling the resources to provide adequate retirement income and financing of health care. I don't think that's the kind of responsibility that can be easily laid on the States, on the families, or on communities. I think that the amount of resources that the national tax structure marshals at the Federal level allows a lot of things to happen at that level that can't really happen as easily at other levels.

My job this afternoon is to talk a little bit about some of the factors behind the fact that a large proportion of older women in our society are poor, and why some of today's trends, if they continue, will mean that even larger proportions of elderly women will be in economic distress in the future.

The problems: the current Federal administration's rhetoric would have us believe that most older Americans are OK financially, but the fact is that over a quarter of unmarried older white women have incomes below the poverty line and nearly two-thirds of unmarried older black women have below poverty incomes.

We are talking about 2 million older women living on incomes below what the Census Bureau estimates would be required for survival on an emergency basis. And another 200,000 older married women are living in a couple whose income is below the poverty level for couples. Now, I don't call that financially OK. I think it is also important to remember that the poverty level, as the Census Bureau defines it, is not supposed to be something that you can actually live on.

In addition, millions more middle class older Americans face poverty in later life because they have no way to protect themselves from the economic ravages that can result when one or both members of an older couple need long-term care either at home or in an institution.

Private long-term care insurance is largely unavailable, and literally the only recourse most couples have is to spend their assets, become paupers, and settle for the quality of care that Medicaid will support, if, indeed, they can find a provider that will provide their care for Medicaid only.

Finally, the aging of the older population is going to mean greater and greater numbers of older people, especially at the very advanced ages, and here I'm talking about 90 or better, which will

mean greater likelihood that people, especially older women, will be outliving their assets. The very old aged in institutions will be more impaired than those in nursing homes today, and this means that the cost of caring for them will be greater than the current average.

What are the causes of some of these income problems? It's no great mystery about why older women are so much more disadvantaged as a category as compared to older men. We have known the causes for years, but thus far we have lacked the will to do what is needed to eliminate our greatest human rights inequity.

Sexism, the belief that women are generally less capable than men and fit only for certain jobs, has resulted in an unique position for women in relation to jobs. To many, a woman's place is in the home, and many women do spend several years out of the labor force as nonemployed housewives.

Those women who are employed tend to be concentrated in jobs that fit the stereotype of "women's work." More than three-fourths of employed women are employed as clerks, typist, teachers, machine operators, salesclerks, food service workers, registered nurses, and nurse's aides. Despite the impression that things have improved, the top 10 jobs for women today are exactly the same as they were 45 years ago. Women's work tends to be low-paying work, especially compared to the pay men with similar education get for jobs requiring similar skills.

For example, college-educated white men aged 55 to 64 in a clerical job averaged an income of $19,800 in 1979, compared to an average income of only $12,300 for a woman with identical characteristics. In other words, the man made 61 percent higher income for the same types of jobs.

Not only does this drastically affect the capacity of women to save for retirement, it also influences the level of Social Security retirement benefits they will get, too, because Social Security retirement benefits are tied to average wages. Thus equal pay for equal work as an issue has great ramifications, not only while the person is in the working years, but for later life, as well.

In addition, women's employment tends to be concentrated in sectors of the economy where private pensions are less prevalent. Office clerks, salesclerks, food-service workers, and the like, tend to work for small businesses that do not have private pension plans.

Many of them work for employers that are not even required to conform to the Employees Retirement Income Security Act. Only about 40 percent of women who retired in 1970, were entitled to private pensions in addition to Social Security, compared to about 60 percent of men. This differential access to private pensions to supplement Social Security plays a major role in the economic troubles of older women.

Another major part of the difficulty comes from the assumptions that were used to structure our pension systems. Social Security is based on an assumption that benefits will go mainly to couples rather than individuals. Indeed, if we look at the earnings replacement for couples—that is, the retired worker who receives the benefit, and spouse who receives a 50-percent spouse benefit—we see that Social Security replaces about 55 percent of earnings prior to retirement.

This isn't too bad considering that economists estimate that you only need about 60 percent earnings replacement in retirement to retain about the same preretirement level of living. But the picture is significantly different for aging single retirees. They only get 37 percent of earnings replacement, and for women, the figure is less than 25 percent.

So you can see that the spouse benefit creates a very different situation for couples. And the assumption that the spouse benefit is going to be going to most retirees is a questionable one at best, and it particularly negatively affects older women.

Social Security retirement benefits are also based on the assumption that employment will be uninterrupted over a period of 35 to 40 years. And when the benefit is computed, the number of years that a person is out of the labor market is included as years of no income which brings the average down considerably. This also tends to depress the amount of Social Security benefits.

Another inequity relates to the spouse benefit issue. Married women who are entitled to retirement benefits in their own right have to choose to take their own benefit or take the benefit equal to 50 percent of the husband's benefit. Because of the low pay women typically get, many are better off to take the spouse benefit. Yet they have contributed to the system for decades, only finding themselves getting the same benefit as a housewife who has never been employed. Many women feel that at least a modestly increased spouse benefit, say 65 percent instead of 50 percent, should be available to those women who have contributed to the Social Security system.

In the area of long-term care financing, it is common knowledge that health care costs are increasing at an alarming rate and continue to do so presumably no matter what we do. The medical model of providing high-technology medicine to quickly treat the sick and get them back into the community may be sound when applied to a 10-year-old with a ruptured appendix. But when the issue is potentially years of care to a severely impaired victim of Alzheimer's disease, the quick fix in a high-tech environment is of little use. Yet the means we have created to finance health care has been dominated by the hospital/physician model. In effect, Medicare provides very little long-term care.

Private long-term care insurance is not available to most people. The effect is that middle-class Americans who have worked hard and saved their entire adult lives find themselves in the tragic position of having to spend down to the point of becoming paupers in order to qualify for the only program that will finance long-term care, and that's Medicaid. And even then they cannot be sure of getting the care they need because most care providers try to limit the number of Medicaid residents they have because Medicaid does not fully reimburse the costs of care. And as the average age of the older population increases, this situation is going to become more and more commonplace.

The aging of the older population is also a factor. Many Americans seem to think that we have already gone through the process and are now a "gray America." But the fact is that most of the growth in our older population is yet to come. Between 1985 and

the year 2050, half of the population growth in the United States will occur at the upper ages as the very old-age categories fill up.

To give you a concrete example of this, in 1970, there were 127 patients age 95 or over admitted to Cincinnati area hospitals. In 1980, there were 1,629 patients age 95 or older in Cincinnati area hospitals, a 1,182-percent increase. This very rapid increase in old, old populace will stress our systems for caring for the frail elderly, perhaps beyond the breaking point.

Yet, we hear of health-planning agencies being disbanded and new nursing home construction being prohibited because there is no need for more space in nursing homes. Maybe if there were more competition in the nursing home industry, then operators who get cited year after year for violations of State health department regulations would no longer have captive clients—people who literally could go nowhere else because no other facilities exist—and would have to provide more adequate care or be forced out of business.

Likewise, we need more in-home services at reasonable rates. This is an area where the growing density of older population will probably help by reducing the travel costs connected with providing in-home services. Nevertheless, families will continue to be the main providers of such services, as they are now, and in the future the providers of care to the very old will themselves probably be old, and this will affect their physical capacity to lift the older family member for such things as baths, and it will also affect their financial capacity to hire others to assist them. All of this is quite relevant to the issues of today's hearing because most of the very old and frail elderly will be women and most of their care givers will, themselves, be older women. What plans are we making now to address these problems?

Solutions: We have an equal pay for equal work law in our society. What we lack, at this point, is a commitment to providing the machinery to enforce it. At the national level we definitely need to provide more effort in that direction. If you look at the budget the Equal Employment Opportunity Commission has available for enforcing the legislation that it is charged with enforcing, the financial resources are pitiful in relation to the job to be done.

In most European Social Security type retirement systems, spouse's benefits either do not exist or are minimal. Instead, individual workers receive pensions that replace about 50 to 60 percent of their preretirement earnings. We could enact a similar system. Couples in which the wife had never been employed would be no worse off than they are now, but two earner couples would be much better off, as would single individuals of both sexes.

But isn't this ridiculous given the tight circumstances that Social Security is already in? Well, not really. We could double the percentage of payroll tax going into the Social Security trust funds and still not be at the average for industrialized nations in this world. In addition, there is no strong reason why the payroll tax is the only mechanism we could use to finance pensions. It's just the one we've been using.

Some countries also offer a homemaker credit. For example, we could allow up to 10 years credit for child rearing. The credit could be tied to the median income for working women, and could

be applied in computing Social Security retirement benefits. The documentation of it could be a part of the couple's annual tax return, and financing the extra cost could be done by using general tax revenues or could be done by any number of other mechanisms.

Some countries allow the housewife to contribute, herself. For example, in Japan, housewives are allowed to make a contribution to Social Security in order to gain retirement pension credits as nonemployed housewives. The plan is voluntary, and 80 percent of Japan's housewives participate in it.

In 1981, the President's Commission on Pension Policy recommended that all employees over age 25 should be covered by a minimum universal pension system to supplement Social Security. The program would have been financed by a 3-percent payroll tax paid by employers. This was, and is an excellent idea. But in the economic climate of 1981, it didn't stand a chance. Regardless, we still might need to find some way to make supplemental pensions available to the majority of older American workers who do not work for Fortune 500 companies and who have no private pensions and no carryover into retirement of important fringe benefits, such as health insurance.

In the area of long-term care, there are a few things we could do to ease the plight of older women. First, we could do a better job of training family members to be care providers in the home. We could also be better at giving respite care to ease the burden on families.

We could also do more to recognize the financial sacrifices that families make that save the public millions of dollars. For example, in 1982, a son paid $12,000 for care of his mother in a nursing home. For that, he got a $750 tax deduction. But he had to pay income tax on the remaining $11,250, which, in his case, amounted to $3,038, even though it was never part of his disposable income. Thus, on top of the $12,000 indirect costs of care for his mother, our tax system charged him an additional $3,038. Real fair.

Finally, we need to provide incentives for the insurance industry to develop long-term care insurance. This is a very conservative, industry that may need some encouragement to proceed. Yet, we all need protection, and women need it most. We may not be able to expect the industry to come up with plans that will cover all of the costs of lengthy long-term care. But they surely can come up with defined benefit plans that can drastically slow down the asset depletion rate for most older Americans who need nursing home care.

I tried in my remarks to indicate what I think the main problems are, what is causing them, and some of the solutions that we might be able to use. Despite the fact that we face many problems, some of them of long standing, I still remain optimistic because it is our own futures and our futures of our parents and grandparents and children that we are talking about. Our integrity as a nation requires that we respond to their needs. [Applause.]

Senator GLENN. Thank you, Dr. Atchley.

I regret that Karen Nussbaum of the National Association of Working Women, sometimes known as 9 to 5, cannot be with us today. But I am very pleased that her associate, Ella Holly, is here to present testimony on problems encountered by women in the work force.

STATEMENT OF ELLA LOUISE HOLLY, CLEVELAND, OH, RESEARCH ASSOCIATE, 9 TO 5, NATIONAL ASSOCIATION OF WORKING WOMEN, AND PRESIDENT, DISTRICT 925, SERVICE EMPLOYEES INTERNATIONAL UNION

Ms. HOLLY. Thank you very much, Senator Glenn.

I want to thank the committee for inviting me to testify today on women in our aging society. This is one of the major social issues that is becoming crucial as the life expectancy rate continues to grow.

I represent 9 to 5, National Association of Working Women, and District 925, the Union of Office Workers and the Service Employees International Union.

The main point I need to emphasize today is that older women are poor. This is a dual tragedy in that women in the work force don't earn enough money while they are working, resulting in poverty once they are in their old age. I would like to provide you with a few missing facts so that we can explore the issues of age and sex discrimination. Older women in America significantly bear the brunt of poverty in a country that claims to be on the road to economic recovery, almost half of the older women in this country have median incomes of less than $5,000. For women of color the situation is particularly distressing. They are most neglected. Financially, emotionally, and physically. Victims of both sex and race and age discrimination, they live without adequate resources necessary for a decent life. Now is the time to take serious action to reduce inequities that older women experience.

In my testimony today, I want to address three specific concerns with you: (1) debunking some of the myths concerning older women workers, (2) exploring the issues facing older women office workers, and (3) providing you with several specific recommendations for shaping new policies to help remedy the plights of older women in America.

One common myth has it that younger women, and in most cases men, make better employees than older women. Studies have proved this notion false. Older women workers are more reliable and equal if not superior to men and younger women in a variety of ways. [Applause.]

First of all, they have a lower level in turnover. Older women are less likely to leave the work force or change jobs than younger women. Second of all, we can look at their rate of absenteeism. Absenteeism rates are virtually the same for women and men. The third myth focuses on job performance. Performance studies show that older workers perform as well or better than those individuals who are 30 to 40 years their junior in mental, as well as intellectual capacities. Finally, there is the myth of educational attainment. Men and women usually have the same number of years of schooling, but unfortunately, it only pays off, in most cases, for men.

Although an increasing number of older women are entering the work force, growing numbers of women over 40 who want to work encounter enormous barriers seeking jobs. Many can find no job at all, others are forced to work part time, and still others take jobs which do not offer adequate compensation, or utilize their skills and experience.

I'd like to raise three key issues older women encounter on the job. Specifically I want to focus on inadequate pay, lack of pension coverage, and age and sex discrimination. Each of these issues are related to a woman's ability to enter the work force successfully, and successfully establish herself in a career in order to maintain a quality of life during her retirement years.

The first one is inadequate pay. The issues of clerical wage illustrates perhaps more clearly than any other that older women face dual discrimination. Not only do older women workers contend with low wages traditionally paid to women, they also look back on years of hard work and find people half their age right behind them and gaining quickly.

Women in the work force generally reach the peak of their earning capacity by age 35, while men's earnings continue to rise. There are several reasons why. First, salary ceilings in the wage structure of most organizations do not reflect the standard cost of living. Lower and middle level clerical workers, for example, can go for years without across-the-board pay increases once they reach their salary ceiling. By salary ceiling, I mean being at the top or the peak of the career ladder.

Older women often find themselves at the top of a salary level with very limited chances for advancement, and at the mercy of the company's timetable for raising the salary level of the entire category. This experience was discussed by one of our members, who said,

> You would think that 20 years of doing this work would count for something. But they started me at entry level salary, and now, I'm making only 10 cents an hour more than the kids just coming in. And to add to it, when I get my next annual raise, I'll be at the top of the salary level for my job category with no where to go. Then what, do I stop advancing at 43?

This particular woman works for an insurance company as a promotions assistant. The wage discrimination that place women through their careers has a devastating impact on their retirement incomes and retirement incomes systems themselves have a discriminatory effect on women. The problem here is that many companies don't have pension rates for clerical workers. About 50 percent of all working women are in jobs with no pension plans.

A substantially higher number of women are concentrated in sales and service industries which have the fewest pension plans. These jobs are the lowest paying in the country, and saving for retirement is, therefore extremely difficult. One of the key factors for the lack of coverage among women is the vesting process. Most pension plans today require an employee work for a single company for 10 years before she, or he, becomes vested. And by vested I mean eligible to collect the benefits.

Such slow vesting is perhaps the most glaring inequity of the private pension system. It is totally unrealistic for a vast majority of working women as well as working men.

Inadequate pay and poor pension systems reflect the double whammy inflicted on the older woman worker. She must contend with both age and sex discrimination. The older minority women, however, encounters a triple whammy—being a woman, a person of color, and being old.

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The Retirement Equity Act, which Senator Glenn has cosponsored, was recently signed into law, it was an important first step in confronting the problems of age and sex discrimination facing older working women. And we applaud you for your efforts.

In the coming years, however, Congress can go much further in making reforms to improve the situation for women in America. Here are some things 9 to 5 recommends specifically:

First, adequate funding for the Equal Employment Opportunity Commission to insure that EEOC has the resources to enforce the Age Discrimination in Employment Act, and laws prohibiting sex and race discrimination along with adequate funding. I also want to add we also need new strategies for inforcing the laws. I think some of the strategies we currently have really don't touch upon the problems that we are facing in the areas of age and sex discrimination.

Second, passage of the Vesting Integration and Portability Act, or the VIP bill, which will be introduced by Congresswoman Ferraro and Senator Kennedy. If passed, this bill would make three important changes needed for pension reform. These include:

Vesting.—The bill would require pension plans to allow employees to vest in 5 years instead of 10.

Integration.—It would limit the extent to which pension plans can take into account and subtract a person's Social Security benefits.

Portability.—The bill would allow people to withdraw a portion of their vested pension benefits for investment in IRA's so money continues to earn interest.

This VIP bill will seek to address the problems of adequacy and equity that plague the current pension system. Once introduced, we urge you to support it, so that we can ensure security for people once they reach their later years.

Finally, we urge continuing research and legislation to achieve pay equity so that working women of all ages and colors are paid the full measure of their skills and experience.

Again, thank you for giving me the opportunity to share some of our insights. [Applause.]

Senator GLENN. In 1983, Joyce Chapple was appointed director of the Ohio Commission on Aging. With the elevation of the commission to a department on aging, Ms. Chapple became the very first Ohio cabinet level director of aging. The department has focused recently on programs to support older Ohioans in their home, instead of in institutions. Some of the things we talked a bit about this morning are housing and alternative community based services.

STATEMENT OF JOYCE F. CHAPPLE, COLUMBUS, OH, DIRECTOR, OHIO DEPARTMENT OF AGING

Ms. CHAPPLE. Thank you very much, Senator Glenn.

I am Joyce Chapple, director of the Ohio Department of Aging. The Ohio Department of Aging is concerned with all issues that affect the well-being of Ohio's older citizens, and I appreciate the opportunity to testify and participate in this public policy panel focusing on women in our aging society. I would like to commend

you, Senator Glenn, for your leadership in calling this hearing to explore the issues facing women in our aging society. We are, indeed, an aging society, particularly in Ohio.

In the next 20 years, the number of persons 65 and over will increase by 25 percent, while the whole of Ohio's population will increase by only 4 percent. Ohio's older citizens are growing faster than any other group, and by the year 2030, it is projected that one in every five Ohioans will be over the age of 65.

I will begin by briefly discussing several Government policies and programs which encourage older Americans to continue to be contributing members of their communities. Additionally, I want to share my perspectives on some of the major issues which impact the lives of older women.

Dr. Atchley has touched upon some of the points that I had included in my notes, and Ms. Holly has also touched upon some. That says something about the urgencies of these issues, particularly as it relates to economic security.

Eight programs can be identified as contributing in a major way to America's policy with respect to its older citizens. Several of these federally sponsored programs are referred to as universal. Universal programs are those available to all persons based on their age.

These programs include Social Security, Medicare, and services provided under the Older Americans Act. The Older Americans Act of 1965, and it's numerous amendments over the years represents a significant outcome of the public policy process. Major provisions of the act provides funding for social, supportive, and nutrition services for millions of our older population. Many older citizens are able to maintain their independence as a result of the provisions of certain services.

Nutrition programs are an excellent example of these services. In Ohio, we are able to provide 6,500,000 meals annually, and of this number, 1,250,000 are home delivered meals. Other services made possible by the Older Americans Act include: Transportation, health, education, informational and referral, legal services, and a wide variety of other social and supportive services.

These programs provide a tremendous support for our older citizens. However, it must be recognized that there are serious unresolved problems facing many of Ohio's older population.

The overwhelming majority of older persons live full, enriching, and satisfying lives in their own home within their communities, close to their neighbors, friends, and families. Notwithstanding this fact, many older persons suffer from chronic illness and lack adequate health care, transportation, and security—both economic and personal—in order to remain independent and to carry on the normal activities of daily living.

It is our responsibility, I believe, to face the basic dilemma of providing sufficient services to enable the healthy to remain healthy, the well to remain independent, and, at the same time, to support those who suffer chronic impairments to live in the least restrictive environment, with ample assistance from family, friends, and supplemented with quality services from a variety of human service agencies. We must continue the developments which will provide alternative living arrangements and community

based long-term care for our older citizens. We must expand the programs provided under the Older Americans Act, as well as support other programs that encourage older Americans to continue to be contributing members of their communities, such as the title V Senior Employment Program, and ACTION's Older Americans Volunteer Programs.

Two weeks ago, I had the pleasure of participating in a ceremony at the Deaconess-Kraft center in Cleveland to pay tribute to over 400 dedicated volunteers. These volunteers provided over 60,000 hours of assistance to over 40 agencies in Cuyahoga County during the past year. Older persons continue to be a tremendous resource in assisting others with greater needs.

It is vitally important that services, such as those provided by the volunteer programs, are adequately funded. It is equally important to begin now to work diligently in developing solutions to certain critical problems facing older persons now, and increasingly in the future.

Some time ago, I read testimony of a hearing of Congressman Claude Pepper's Select Committee on Aging. In his introductory remarks, Representative Pepper pointed out that when he was born in the year 1900, only 5 percent of the population of this country was over 65 years of age. Now, 80 years later, this number has increased to 11 percent.

The purpose of the hearing, he said, was to see how this vital and growing segment of our population was getting along. His committee was hearing cries of older persons whose dreams of retirement had turned into nightmares. The statistics he cited were frightening, some of which you have heard today. One in three older men, and two of three older women are being forced to survive on annual incomes of less than $4,000 a year.

What is sometimes overlooked when we are discussing aging, is the fact that for the most part we are talking about women. Look at the demographics and what they reveal about the "graying of America." In 1982, the Census Bureau reported that there were 26.8 million persons over the age of 65 in this country. Of that total, 16 million, or 60 percent were women; 10,800,000 were men.

In Ohio, which ranks seventh among the States with the largest older population, we have over 1,278,000 persons in that age category, of whom 783,000, or 61 percent, are women; 494,675, or 39 percent, are men.

Nationally, and Ohio mirrors this trend, there are 147 women per 100 men for the total 65-plus population. In the 65 to 74 age category, the ratio is 131 women per 100 men. As we go up the age ladder, the disparity grows.

Income security is by far the issue of greatest concern to most older women. I want to illustrate a brief summary of the economics of aging for women in this country.

In 1982, the median annual income—total money income from all sources—for persons over age 65 was $9,188 for men, and $5,365 for women. Table 1 shows both the lower income of older age groups and the income differences between men and women, partly attributable to women's differing labor force participation.

TABLE 1.—TOTAL MONEY INCOME IN 1982, BY AGE AND SEX

Age	Men	Women
45 to 49	$21,952	$7,549
50 to 54	21,112	7,449
55 to 59	20,226	6,195
60 to 64	15,536	5,691
65 plus	9,188	5,365

Note.—Poverty level in 1982 for an older person living alone: $4,626.

Source: Census, p. 60, No. 140, table 10.

Older women are disproportionately poor, comprising over 70 percent of the aged poor. Table 1 illustrates income distribution through the elderly population. It shows what proportion of older persons have incomes at or above a given level.

In 1982, one-third of all older women had incomes under $4,000, and about 40 percent had incomes over $6,000. Slightly less than half of older men had incomes over $10,000; only 20 percent of older women had incomes exceeding $10,000. When income data is shown by race, the low-economic status of minorities, especially women, is evident. Older black citizens have substantially lower medium incomes than white citizens.

TABLE 2.—MEDIAN TOTAL MONEY INCOME OF PERSONS 65 PLUS IN 1982 BY SEX AND RACE

Race/Spanish origin	Men	Women
Total	$9,188	$5,365
White	9,689	5,594
Spanish origin	6,210	3,671
Black	5,214	3,605

Source: Census, p. 60, No. 142, table 45.

A recent study prepared for the Congressional Caucus for Women's Issues, indicates that the Nation's 16.4 million elderly women still bear the brunt of poverty and neglect in America. The report, prepared by the Women's Research and Educational Institute, says, "Almost half of the older women had median incomes of less than $5,000, compared with fewer than one in five men." Another significant finding of this group points out the fact that more than 80 percent of older women, householders live alone. I feel that the isolation issue is as serious as the economic security, and some would agree, to some extent, more serious.

Women over 40 are the fastest growing segment in the U.S. labor force; 53 percent of women age 40 to 64, are either in the work force or looking for employment. Of those in the work force, half are in jobs with no pension plans. In general, women receive less than one-half the retirement that men receive. An estimated 4 million women age 45 to 65, have no health insurance. The problems of women in the workplace continue to multiply as you research the issue. Two points were very clear, however. The majority of women age 40 to 64 are in the labor force today, and trends indicate that they will be there in even greater numbers in the future. As we look at ways in which being a woman and being older affects the work life, the urgency becomes clear. Action must be taken

now if equity between the sexes and the generations is to be a reality in the 21st century.

I would like to mention two areas that are related issues, which need attention.

The area of training needs. Very few men over 30, but large numbers of women, are new entrants into the labor force. Millions of midlife women need training or retraining to meet special requirements of today's job market.

There are several ways in which older women could be served under the new Jobs Training Partnership Act [JTPA]. This might occur in the mainline programs, in programs for older workers, and in special programs for older Americans—a special set-aside for low-income persons over 55. While advocates are pleased that JTPA targets older persons, historically such special target programs have the unhappy effect of absolving the rest of the program of any responsibility to serve the targeted group. Older women must be equitably served in all parts of the program.

Since the private sector involvement is the foundation of the JTPA Program, one could ask how public policy, as well as private advocacy can encourage employers, particularly small businesses where the largest numbers of positions will be available, to hire older workers, and older women, in particular.

In terms of care-giving responsibilities, I would like to point out that this, even though it is a very highly complex issue, is a barrier to employment faced by an increasing number of women in their fifties and sixties. Their responsibilities as care givers. The "dependency squeeze" is a growing phenomenon emerging from increased longevity, which does not necessarily mean longer periods of good health, increased labor force participation by women, and in many instances, changes in marital status.

Contrary to popular myth, most frail older persons are not living in institutions. Their care givers are nearly always middle-aged or young-old women: Spouses, daughters, siblings, daughters-in-law, grand-daughters. It is estimated that 78 percent of women age 40 have a surviving mother, for example. Care giving frequently becomes a full-time, unpaid job.

Research suggests that 40 percent of women 40 to 65 have child-care responsibilities, and 10 percent have responsibilities for frail older persons in their homes. In women-headed households, almost half have either child or elder care, or both. As the care giver moves through middle-age, the dependency burden shifts from care of children to care of older relatives. Data from the Survey of Income and Education in 1976, suggests that 10 percent of women age 50 to 54 and 17 percent of women age 55 to 59 are caring for older persons who live with them.

The impact of the care giver role on women's employment and employability and thus, on their retirement income, has not been adequately explored, but will become increasingly problematic in the years ahead.

The economic problems associated with care giving are examples of the ultimate cause of women's low income in retirement; that is, the devaluing of the work women do, whether in or out of the pay labor force. Until women receive equitable economic returns for

their labor, older women will continue to be disproportionately poor.

Thank you very much. [Applause.]

Senator GLENN. Thank you, Joyce.

The Older Americans Act, as you know, there has been very widespread support in Congress for that act. That act deals with a number of programs, nutrition, senior centers, title V workers, and so on. And I believe I'm scheduled to go to the White House tomorrow for the signing of the 1984 Older Americans Act Amendments. So we are seeing those put into effect tomorrow.

I'll be happy to go. I haven't been invited over there too many times in the last year.

The Governor has to go. I appreciate very much his being here with us today. Governor, thank you.

Governor CELESTE. Thank you very much, Senator Glenn.

I just want to say thank you very much, Pam. I failed to introduce Pam Brodie who is interpreting for us and has been with us this afternoon.

Senator GLENN. Our third panelist is Dr. Jerome Kaplan from Mansfield, OH. In addition to being a skilled nursing and rehabilitation facility, Mansfield Memorial Homes operates retirement apartments, a 50-unit sheltered living program, respite services, a senior center for home health aide services and a variety of day treatment and supportive treatment for the elderly. Dr. Kaplan also serves as an adjunct professor of sociology at Ohio State University. I would add, also, that Dr. Kaplan is not a come-lately person to this problem of the elderly.

Doctor, you and I are both getting older faster and we are going to join the ranks here faster than we probably wish. But Dr. Kaplan has been working in this field for some 25 years, and is so well known and well thought of in this field that he's past president of the Gerontological Society of America, has attended a number of international meetings, and was the American and Western Hemisphere representative to the international meeting held in Tokyo in 1978. He also represented our country at earlier meetings in Moscow, Copenhagen, Jerusalem, and other world centers.

And more recently than that, he participated in the White House Conference on Aging in 1981, and was an important representative to the Women's Task Force of that group. And so these are quite impressive credentials, and Dr. Kaplan, we are particularly glad you are here with us today, and we look forward to your testimony.

STATEMENT OF DR. JEROME KAPLAN, EXECUTIVE DIRECTOR, MANSFIELD MEMORIAL HOMES, MANSFIELD, OH

Dr. KAPLAN. Thank you very much, Senator Glenn.

I do not know if we are to be counted among the male survivors, not quite 65, but I'm beginning to think that my days are exceedingly numbered, perhaps even into minutes and seconds. As I look at the audience, I am not sure whether or not the males here are primarily androgynous, if they were dragged here by their spouses, or if they have a true interest in the subject.

Since Dr. Seltzer is with us, I would like to urge that she develop a fantastic book on Seltzer homilies called Seltzerisms. I am sure it would be a best seller. And if I, too, were paranoid, I would question the Governor's leaving right before I was going to speak.

But since I'm not paranoid, I will speak from notes. My prepared paper is very sizable.

Senator GLENN. Your paper will be entered into the record in full.

Dr. KAPLAN. Thank you.

One of the items I would like to mention that I hope will be passed back to the Governor in terms of the State of Ohio, is a followup to Dr. Seltzer's comments. And I would like to carry it even a stage further. I would urge a dramatic change in the perspective of the geriatric and gerontology education in Ohio. Those of us who helped to develop the geriatric programs within the colleges of medicines in the State of Ohio, now believe it incumbent to develop gerontological education throughout our State. I would carry it to the point where with the significant changes in the population, we should insist every college student have a basic course in gerontology. Furthermore, we should go into our public school system, especially the high schools in order to transmit such information.

This is part of what we have referred to as our preventive program. Now, the points that I will be making will, in most instances, corroborate some of what has been said, out in several instances will have a somewhat different perspective. In at least one instance, a differential view will be presented.

A comprehensive care system is what we have been discussing in various ways, including our protective subsystems of family, Government supports, and community resource types of whatever nature. As we look at the latter, we have moved into the theory of shared functions; namely, effective coordination among formal structured organizations of our society and the informal organizations of which the family, neighbors, friends, church-related functions, and other types of eleemosynary bodies become the key.

Everyone has a piece in the pie, so to speak, rather than the pie coming from one particular origin. As we look at some of our Ohio statistics, which are not too much different from the Nation as a whole, we recognize that with three out of every four Ohioans over the age of 85 being women, and with 60 percent of all people over 65 being women, it is obvious any discussion on health care will have direct relevance on older women in our Nation.

Upward of one-third of the elderly are in need of various services. This is a different statistic than the usual quote which states 5 percent of our population is in institutions. Therefore, it is implied 95 percent of our population is doing pretty good; 95 percent are not doing that good, as we should well know. We further recognize there are variable reasons as to why an older person resides within the institution. As we take a look at the totality of the services being offered as well as the lack of services, upward of one-third of our population is in need, of those who are over 65, of our varied services.

I would like to carry this a bit further. In addition to upward of one-third being in need of these services, and with the dramatic growth in our elderly population of which the vast majority by far

are women, we are essentially talking about giving greatly expanded services to elderly women at home.

I would like to offer four basic philosophical and principal points as we pursue our basic topic. First, as my assignment is essentially on long-term care and its relationship to the family, no long-term care system should consciously accept its role without the acceptance of the complimentary role of the family. Second, long-term care systems should be willing to accept the common good of the family over its own good. This is tough for any provider to be willing to accept.

Third, the long-term care system should provide satisfaction for the family. If anything, the long-term care system should insist that the family assist it to provide the quality of service it wishes to provide.

Fourth, the long-term care system should have a sense of direction.

Two themes are emphasized here. First, the long-term care system should exist as an extension of the family, and, second, the developmental or life cycle theory which incorporates the view that successful aging is not determined by normative standards, but by individual standards and each still trying to say one can guide one's own role.

Now, I would like to press on a bit further as we take a look at what we are talking about. What we have been hearing is that we should have alternatives to nursing home care. I suggest a completely different perspective namely, one called alternatives to home care. This makes all the difference in our base of thinking.

Now, if we look upon alternatives to home care as the base, like I kept hearing that home care might be the best sort of service for older people, we are still trying to tag along with continued growth of nursing home beds. So my first major public policy suggestion is that we think in terms of alternatives to home care, and not alternatives to nursing home care.

My second major public policy recommendation is an absolute and complete moratorium on new, added nursing home bed construction and on conversion of hospital beds to nursing home beds.

Now, unless we have these kinds of topics brought out to the forefront, we are going to continue to find the solution for the 1980's and 1990's, which was suitable for the 1970's.

The reason for the latter suggestion is that we will never know whether or not all of these so-called alternatives are true alternatives unless we give them a chance to both begin to be maximized. While we have some very sophisticated programs, we have only made beginnings in other directions.

If we move in the direction of alternatives to home care, then the nursing home as it continues to develop and evolve will find its right direction. And we will for the first time be able to find out whether or not these other services are really going to provide us with answers we currently imply they will.

I would like to ask the audience one little question. Who is the care giver at home for an elderly person?

A VOICE FROM AUDIENCE. Spouse.

Dr. KAPLAN. The spouse. Anybody else?

A VOICE FROM AUDIENCE. Daughter, children.

Dr. KAPLAN. Daughter, daughter-in-law. Do I hear any sons?

A VOICE FROM AUDIENCE. No.

Dr. KAPLAN. All right. Now, I would like to throw out a third basic piece of public policy. Our society has dramatically changed, and it seems as though one piece of public policy forgets it has a bearing on another piece of public policy. We are hearing there are more women in the labor force than ever before. We are hearing that this is not an apparition, that it will continue to grow and grow and the big push will be for equality of pay commensurate with the type of service that one is doing.

So where is this marvelous and great fantastic labor pool of returning back to 18th and 19th century America when women had little or no choice. We heard the marvelous trio this morning, grandmother, mother, and daughter. No one asked the question of the granddaughter, what would happen if your mother reached the point where she needed to be looked after while you were looking after your own small children? That would have been a marvelous question to ask, at that point in time.

It is exceedingly difficult for families who are faced with that decision. We no longer have that form of labor pool which we once had. And the reason why Japan does not put as much as we do of our gross national product in health care is because they have slave labor. In general, their women would not be sitting here in the audience today like our American women are in this audience. We have to recognize the differences among our various cultures. Ours may still be freest of the cultures in allowing movement to take place.

The fourth basic piece of public policy is the recognition that all traditions need not be lost. There will still be some women who would prefer to have the option of looking after a member of the family if they had that particular option, such as not losing the income from being at a job.

So we should explore the potential and the realities of paying a care giver who looks after somebody at home, who is usually an elderly woman. When it is the spouse, it is usually the wife is looking after the husband until he dies.

On the other hand, a fifth piece of our public policy is to recognize that while three out of four elderly have families, not all families provide care. For those who do give care, the care is ordinarily given at the lower level of the spectrum of need, and the greater the amount of care required by the older person, the less the family is able to follow through.

Long-term care refers to a long and indeterminate period. The final point that I would like to make is to suggest that health care costs are controllable, even on this indeterminate basis. However, they are controllable in our society only if we are willing to look upon the frail elderly dependent person as less than a person, or in other words, if we are willing to give the lowest denominator of care giving, I find it most difficult to believe our society, with the value system we have, that we are willing to settle for less than what we think we ourselves would need as we get older.

If we recognize long-term care encompasses an indeterminant period of time, and if we recognize that older people are as much

human as anybody else, then we can more fully accept the growth of health care costs.

I would add one final caution, however. If we believe home-care-type services are less costly than institutionlly based services, we should acknowledge we have not appropriately accessed scientific studies which compare same groups of people. What we have is a variety of studies with myriad and contradictory indicators.

So we can say, yes; there is a person in XYZ nursing home, for example, who is there because she had a hip fracture. And then we can say, yes; there is a person in the XYZ individual home that is one's own residence who has a hip fracture, and it costs less to look after the latter than the former. Well, it may or may not be true. It depends on all the factors that are involved in reference to a hip fracture.

With these brief comments, I would like to adjourn for the moment, and, I, myself am eager to listen to Anna Brown, who has been telling me she has the most sensational words than anyone has ever heard since the last time she talked. Thank you. [Applause.]

[The prepared statement of Dr. Kaplan follows:]

PREPARED STATEMENT OF DR. JEROME KAPLAN

I am Jerome Kaplan, executive director of Mansfield Memorial Homes which is a multiprogram direct service foundation, and adjunct professor of sociology, The Ohio State University. I have devoted my career since 1950 to the aging field. I am honorary editor-in-chief of The Gerontologist and past president of The Gerontological Society of America.

Titmuss [1] notes that ". . . we can not inquire about quality standards of family doctoring without taking account of all the facilities and tools, medical and social, which are or might be at the service of the practitioner and the patient's family."

The relationship of the individual to a comprehensive health system includes not only the general environment but the many protective subsystems, such as the family, and, more broadly, the public-private organizations of income maintenance and health care delivery. The individual's index of health and his ability to rally from insults depend not only on his own capacities but also on the supports necessary and available to achieve optimum functioning. Accordingly, the effectiveness of comprehensive long-term care programs must be measured in terms both of the elderly person's response to the insults to which he is exposed and of the extent to which the health system strives to enable him to function. An acceptable index will be found in the development of scales for evaluating activities of daily living.[2]

Townsend,[3] in attempting to measure disability, concluded "that the presence of a particular disease does not necessarily indicate for any given person the inhibition of activity which results from it." To follow, the notation that four out of five elders suffer some chronic condition insult does not necessarily indicate the extent of impairment of function.[4]

While 81 percent of those over 65 suffer some chronic illness, 33 percent have no physical limitation on their activities; 7 percent have some limitations, but not on their major activity; 26 percent have limitations on major activity; and about 16 per-

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[1] Goldberg, E. "Helping the Aged." National Institute for Social Work Training Services. No. 19. London, Allen and Unwin, Ltd., 1970. p 13.

[2] For discussion of activities of daily living research see Lawton, M. P., Brody, E. M. "Assessment of Older People: Self Maintaining and Instrumental Activities of Daily Living." The Gerontologist, 1969, 9, 179–186; Brody, E. M., Kleban, M. H., Lawton, M. P. "Excess Disabilities of Mentally Impaired Aged: Impact of Individualized Treatment." "The Gerontologist," 1971, 11, 124–133.

[3] Townsend, P. "Measuring Incapacity for Self-care." Processes of Aging. Edited by R. H. Williams, C. Tibbits, W. Donahue. New York. Atherton Press. 1963, vol. 11, p 83.

[4] McMullan, J. J. "The Prevention and Management of Disability in General Practice." J R Coll Gen Pract, 1969, 17, 83.

cent are unable to carry out their major activity. Thus, approximately half of the elderly are somewhat disabled because of a chronic illness.[5]

The specific level of mobility is of particular importance. Eight percent of the noninstitutionalized elderly are bedfast or housebound. In addition, 6 percent have limited physical ability to move in the community. Overall, more than 30 percent report difficulty in walking stairs.[6] Physical disability as a correlate of aging has been extensively documented.

Limitations of function are also imposed through mental impairment. Estimates of the incidence of mental impairment among the elderly vary from 10 to 25 percent.[7] Rates of psychosis, symptoms experienced as physical illness and organic mental disorders, as with physical disabilities, rise with advancing age.

There is mounting evidence of the rehabilitation potential of the elderly by practitioners in the field. Yet somehow this has not been translated into practice. Considerable research has dealt with negative attitudes that permeate the area of geriatrics. It was found that both administrative and treatment staff inappropriately fear that the elderly are unresponsive and unrehabilitable. Popular misconceptions about treatability often delays seeking help until a crisis develops.[8]

A system of comprehensive long-term care delivery should provide medical, health and support services to enable the elderly who are physically disabled and/or impaired to utilize those resources.

Parsons points out the importance of ideological aspects of American society with respect to the health goals. The valuation of the "achievement" is heavily emphasized in our society, an "attitude which asserts the desirability of measuring the problems of health and from that, for the individual sick person, the obligation to cooperate fully with the therapeutic agency, that is to work to achieve his own recovery."[9] The elderly are a part of the same cultural scene.[10]

By any of the measures of physical, mental, and environmental disability, older people in our society are a high risk group. The nature and number of their problems are beyond individual and family resources, thus requiring public coordination and support. Shanas [11] estimates that the target population of elderly needing services to maintain them at home is one in seven. The Baltimore Chronic Illness Study noted that when considerations of mental impairment and environmental hazards are added to those of physical disability, the need for services is one in three.[12] I would bend in this direction.

The 75 and over group is significantly more vulnerable to the mental, physical, and environmental insults and assaults. While 35 percent of those 65 to 74 with chronic illness were subject to significant impairment of function, 53 percent of those over 75 were similarly limited.[13] Riley and Foner's [14] summary of research findings indicate that rates of all types of psychosis rise steadily by age. Given a functional approach to needs for comprehensive health services, more than a third of the elderly may require support services.

THEORY OF SHARED FUNCTIONS

The theory of shared functions has been selected to set the tone for futuristic long-term care. Shared function is the notion of effective coordination among formal

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[5] National Center for Health Statistics: Chronic Conditions Causing Activity Limitations, U.S. July 1963–June 1965. Ser. 10, No. 51. Washington DC, Department of Health, Education, and Welfare, Feb 1969, p 19.

[6] Shanas and Associates. Old People in Three Industrial Societies. Atherton Press. 1968. pp. 22 ff.

[7] Brody, B. J. "Prepayment of Medical Services for the Aged: an Analysis". The Gerontologist, 1971, 11, 156.

[8] Brown, B. S. "Where do We Go From Here?" Address at the Governor's Conference on Aging, Nashville, TN, Sept. 26, 1973: reproduced in Congressional Record Oct. 3, 1973, p. S18504.

[9] Parsons, T. "Definitions of Health and Illness." Patients. Physicians and Illness. Edited by E. G. Jaco. New York. The Free Press, 1958.

[10] Brody, E. M. "Long-term Care for the Elderly: Optimums. Options, and Opportunities." J Am Geriat Soc, 1971, 19, 187.

[11] Shanas, E. "Measuring the Home Health Needs of the Aged in Five Countries". Paper presented at 8th International Congress of Gerontology, Washington. DC, August 1969.

[12] Commission on Chronic Illness. "Chronic Illness in a Large City. The Baltimore Study." Chronic Illness in the U.S. Cambridge, Harvard University Press. 1957. Vol. IV, table 16, p. 16.

[13] National Center for Health Statistics. Age Patterns in Medical Care. Illness and Disability. U.S., July 1963–June 1965. Ser 19. Washington. DC. Department of Health, Education, and Welfare, 1966, p. 46.

[14] Riley, N. W., Foner, A. et al. Aging and Society. Vol. 1. New York, Russell Sage Foundation, 1968, p. 370.

organizations, informal structures and families if they are to achieve their goals. The idea of shared functions was developed by Litwak and others [15] who reported on this theory in a series of papers between 1965 and 1969. "Shared functions" and its concomitant "balanced coordination" between primary groups and formally structured institutions for the aged were first reported late in the 1970s.[16] In 1978, the theory of shared functions within a meals on wheels service was explicated [17] for a specific service related to the long-term care system other than a nursing home. This was followed by relating the shared function theory to voluntary organizational membership and their possible relationship to rehabilitation from nursing home residence to independence in living.[18] Despite these efforts, however, more documentation is needed on how aging care and service organizations coordinate with other organizations and with families to achieve effective service to the elderly and to their families.

A judgment of what was called the "level of organization" of families was made over three decades ago by Koos (1946),[19] who utilized an internal standard among families themselves rather than defining adequacy against abstract normative criteria for families in American society. His premises can be paraphrased as follows:

(1) The long-term care system should consciously accept its role and the complementary role of the family.

(2) The long-term care system should be willing to accept the common good of the family over its own good.

(3) The long-term care system should provide satisfaction for the family.

(4) The long-term care system should have a sense of direction.

Two themes are emphasized here: first, long-term care system should exist as an extension of the family; second, a developmental or life cycle theory which incorporates the view that successful aging is not determined by common normative standards but by individual standards. A successful long-term care system thus develops its own sense of direction and purpose as it becomes a part of the extended family or, by acting as a quasi-family, becomes the family itself. This is, of course, contrary to efforts by government regulators who strive to decide what is normative for all health care systems. One may think of greater utilization of the long-term care system quasifamily as added to the notions of the nuclear family, the residential family, the residential extended family, and the psychological extended family.

The long-term care system is an extended or quasifamily for both the aging with family who need its services and for those who have no family. Approximately 8 percent of persons 65 and over have never married, and of the noninstitutionalized population 65 and over, 25 percent have no living children. Other documentation shows a 4.7 percent single rate for males 65 years and over and a 5.8 percent rate for females.[20] The succinct phrase "intimacy at a distance" [21] helps to explain the continued high occupancy rate of nursing homes even apart from other factors that have been researched, such as the effect of having adult children on being in an institution.[22] Or, as pointed out in many studies during the past 10 years, as the

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[15] Litwak, E. "Extended Kin Relations in an Industrial Society." In E. Shanas and O.F. Streib (Eds.), Social Structure and the Family. Prentice-Hall, Englewood Cliffs, NJ, 1965; Litwak, E., and Figueita, J. "Technological Innovations and Theoretical Functions of Priamry Groups and Bureaucratic Structures." American Journal of Sociology, 1968, 72, 466–481. Litwak, E., and I. Szelani, "Primary Group Structures and Their Functions: Kin, Neighbors, and Friends." American Sociological Review, 1969, 34, 465–481.

[16] Black, K. D. and V. L. Bengtson, "Implications of Telecommunications Technology for Old People, Families, and Bureaucracies." In E. Shanas and M. B. Sussman (Eds.), Family, Bureaucracy, and the Elderly. Duke University Press, Durham, NC, 1977. Dobrof, R. D. and E. Litwak, Maintenance of Family Ties of Long-term Care Patients. National Institute of Mental Health, Bethesda, MD, 1977.

[17] Kaplan, J. "The Shared Function Theory and Meals-on-Wheels: Maintenance of Independence." In XI International Congress of Gerontology program: Independent Living Styles. (invited presentation). International Association of Gerontology, Tokyo, 1978, pp. 108–109.

[18] Kaplan, J. "Voluntary Organizational Membership and Their Relationship to Institutionalized Geriatric Patients' Rehabilitation." In XII International Congress of Gerontology program: Thematic sessions, abstracts (vol. 2) International Association of Gerontology, Hamburg, Federal Republic of Germany, 1981, p. 54.

[19] Koos, E. L. "Families in Trouble." King's Crown Press, New York, 1946.

[20] U.S. Bureau of the Census. "Demographic Aspects of Aging and the Older Population in the United States." Current Population Reports, Series P–23, No. 59. U.S. Government Printing Office, Washington, DC, 1976.

[21] Rosenmayr, L., and E. Kockeis, "Propositions for a Sociological Theory of Aging and the Family." International Social Science Journal. 1963, 15, 410–426.

[22] Brody, E. "The Aging of the Family." The Annals of the American Academy of Political and Social Science, 1978, 438. 13–27. Palmore, E. "Total Chance of Institutionalization Among the Aged." The Gerontologist, 1976, 16, 504–507.

family begins to fade in terms of direct care, the institution becomes more important in providing care to aged persons who are impaired.

With an increasingly aging population and no major breakthroughs in preventing chronic diseases imminent, the institution will continue to comprise an important segment of the community's long-term care services, even though the question of whether the institution will be integrated into the service system as a whole is still not answered. Between 1974 and 1976, long-term care beds increased by 200,000 per year, with a total of 1,384,000 beds reported for 1977.[23] A projection of 1,750,000 beds by 1990 may be conservative, if we accept the growth pattern. If, however, we accept the figure of 4 to 5 percent of those over age 65 residing in a nursing home at any point of time [24] and if we accept the projection of 30 million people age 65 and over by 1990 [25] we can foresee as many as 1,500,000 beds. But this projection must be modified to focus on the growth of the population aged 75 and over and, therefore, may not be as acceptable a figure as many gerontologists and health economists assume. We should look instead to documentation showing that only about 1 percent of those aged 65 through 69 live in nursing homes while 21.3 percent of the nursing home occupants are 85 years and over.[26] The absolute numbers accentuate these percentage distinctions. Bram, quoted elsewhere, gives us even more startling statistics.

A METHODOLOGICAL APPROACH FOR LONG-TERM CARE

Several efforts have been made in recent years to find better approaches to nursing home bed needs than the traditional Hill-Burton formula based on the number of beds in use. In fact, no formula or model has found general acceptance. Apart from the acknowledged biases engendered by each formula developed to date, they operate without relationship to other aging services. What is suggested, then, is a quasi or extended institutional family formula for testing which relates to the provision of multiple services as an integral component of bed need combined with internal nursing home social provision factors.

I suggest that this methodological approach be composed of three elements. The first would use as a baseline the latest year for which reliable figures are available for services developed and the years when the Older Americans Act, title XX of the Social Security Act, and other entitlement programs went into effect.

The second element would use age 75-plus as the key population for determining bed need since the nursing home population continues to grow older both in admission and in residence. It also helps to compensate for that portion of the population in nursing homes who may better be served in a noninstitutional environment.

The third element should incorporate the service typology of prevention, maintenance, amelioration, and rehabilitation or restoration as a basis for service conceptualization.

Preventive services, as the phrase implies, are those that would keep some older people from entering a nursing home and significantly delay the entrance of others. Preventive services may be classified into several types. One type is long-range or primary prevention, such as education in eating habits or early dental or podiatric care. A second type includes services to assist older people prior to a major social or health disablement and to help them retain the capacities that they possess. We may refer to these as the maintenance services. A third type is that of amelioration, or one of relative immediacy in handling a disorder. The weighting factor becomes larger as one moves from the first type to amelioration and reaches its maximum with rehabilitation or restoration services. Thus, the assigned weights are predicated on professional judgment both of the intensity of service and the depth of the skills required to ensure maximum independence.

Communal aging service descriptions have been provided to us by researchers and clinicians. A collation of this extensive documentation provides us with a list of at least 56 specific services each of which may be categorized and weighted within the typology of preventive, maintenance, ameliorative, and rehabilitation services. However, the existence of a service implies the additional dimensions of quantity, some measure of the amount of use and quality, which can be defined as approval by an

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[23] U.S. Bureau of the Census. Statistical Abstracts of the United States. U.S. Government Printing Office, Washington 1978.

[24] Op cit, Palmore.

[25] U.S. Bureau of the Census. "Social and Economic Characteristics of the Older Population: 1978:" Current Population Reports, Series P-23, No. 85. U.S. Government Printing Office, Washington, DC, 1979.

[26] Op cit, U.S. Bureau of Census, 1978.

accepted governmental or voluntary body such as Medicare, Medicaid, the Joint Commission on Accreditation, or an area agency on aging. Thus, a weighted score for the service could be derived by multiplying the combined quantity and quality scores by the appropriate weight.

Studies on protective services such as that by Blenkner and her associates [27] have shown that newer services identify more new cases and hence increases the overall need for services. The approach suggested here emphasizes a different dimension. The higher the total of weighted points or total available qualitative services, the greater the probability of bed need since the use of care alternatives comes closer to being maximized. One consequence is a greater probability of support to outreach and outpatient type services by the nursing home institution.

Because estimates of the role of services are not included in our predictions, competition and the deterioration of health planning may nevertheless decide the future number of beds.

Fuller detail on the methodological approach may be obtained from a recent article by Kaplan [28] from which much of the above is explicated.

THE FRAIL IN NURSING HOMES: ADDED DIMENSIONS AND COSTS

Howard Bram, Executive Director of the Menorah Park Jewish Home for Aged in Beachwood, OH, is to receive credit for the below excerpts from his May 15, 1984 paper on "The Long-Term Care Facility—A Point of View" presented at the Ohio Conference on the Long-Term Care Patient in the New Health Care Environment, Columbus, OH.

"The long-term care facility serves the oldest, the most frail, the most handicapped--both mentally and physically—and the most dependent of all the elderly . . . There are 1.3 million elderly persons residing in nursing homes. This compares, I believe, to about 900,000 persons in general hospitals at any one moment in time. The elderly in this country are thought of as those persons who are age 65 and over. When thinking about nursing homes, the public generally associates nursing homes with all persons 65 and over. Actually, in the ten year age group 65 to 74, only 1.5 percent are in nursing homes. When we move up to the next age group, 75 to 84, we find that 6 percent are in nursing homes. When we finally reach the age group 85 and older, 23 percent, or almost 1 in every 4 persons, in that age group are now living in nursing homes. More than 75 percent of all persons in nursing homes are age 80 or over. Almost every person in a nursing home is single. More than 80 percent are female. The Census Bureau predicts that the gap in the life expectancy between husbands and wives will continue to increase at least for the immediate future so that that disparity will continue. Therefore, we can appreciate the fact that the typical persons admitted to the nursing home is female, widowed, age 84. Having the experience of managing other long-term system services such as congregate housing, daycare, home delivered meals, respite, assessment, I can safely say that the preponderance of persons being served in those programs also fall into the profile of female, middle 80's. (Note: Kaplan has found those served by the Homemaker Home Health Program averages into the middle 70's, primarily female but not to the same extent as those other services.) A moment now to define long-term care services. Simply stated, it means help, services, and/or living arrangements provided to individuals who are unable to care for themselves because of frailty, chronic illness, or other functional impairments. I would like you to remember the word 'long' in long-term care because long-term care deals with an indeterminate length of time.

"It is generally known in the field that 15 percent of those over the age of 65 fall within that category of those unable to care for themselves. This inability to care for themselves is usually the result of a chronic illness, a functional physical impairment or even more often, a degree of dementia or memory impairment.

"Of the 27.5 million elderly, 4.125 represent the 15 percent who fall within this category. One out of three or 1.375 million are living within an institution. Two out of three or 2.75 million are living outside of the institution and have managed to cope either through their own self-determination and self-reliance, or, through the assistance of one or more caregivers. These caregivers are primarily the spouse, a daughter, a daughter-in-law; rarely a son, and, sometimes a neighbor or a friend.

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[27] Blenkner, M., Bloom, M., Wasser, E., and M. Nielson, "Protective Services for Old People: Findings from the Benjamin Rose Institute Study." Social Casework, 1971, 52, 483–522.

[28] Kaplan, J. "Planning the Future of Institutional Care: The True Costs." The Gerontologist, 1983, 23, 411–415.

(The help provided by these persons is known as the informal care system within the shared function theory).

"However, a large number of those remaining with the community would not be able to do so without the assistance of one or more services from the formal support system, also an integral part of the shared function theory.

"My point of view is that the person residing in the long-term care facility should be known as and treated as a resident and not a patient. I say this because most of those who are in long-term care facilities are profoundly handicapped and will therefore be spending the remainder of their lives within the facility. The facility is truly their only home. They are not acutely ill. They are chronically disabled. The long-term care facility should not be one's permanent hospital. No one should live as a patient in a hospital for the remainder of their life. Every effort should be made to provide these individuals with as much meaningful life activity as it is possible to render. The health care services should merely be supportive so that the resident might accomplish this major objective. Everything the facility does in the way of environment, the respect for privacy, and challenging life experiences should be geared around that concept.

"My next point of view is that in order to attain that objective, the long-term care facility must have a rehabilitation philosophy. Just what does rehabilitation mean in terms of the long-term resident.

"It means that the program is designed around the individual's maximum capacity to function so that a person may do everything one is capable of doing whether that be getting around in a wheelchair by oneself, feeding oneself, participating in a discussion group, participating in a hand-craft activity, mild exercising, receiving professional counseling, and to be surrounded by staff who really care that a person looks forward to the coming of a morning. [Note: Several changes in this paragraph from Howard Bram's original quotation were made by Jerome Kaplan to reflect grammatical flow and gender.]

"A third point of view is that we must recognize that the mental health needs of the aged person within the institution is the most pervasive of all needs of that individual; that even though we are dealing with persons with severe physical problems, the mental health of the individual, his behavior, his fears, etc., require more concern, more energy, and often more time of the professional staff than do the physical needs. In a quality facility, every staff person providing care to the resident must know this and must deal with it.

". . . Look at the reimbursement structure for long-term care services under Medicare and under Medicaid and you will see that the system barely recognizes the value of social services, meaningful activity, cultural, and other social components of care simply because they do not technically fall under the MEDI part of Medicare and Medicaid. We have a system, for example, which rewards keeping a handicapped individual in bed when a true professional knows that confinement to bed is the worst possible treatment for an older person. As a result, those facilities which spend more money and work harder to keep these persons out of bed are penalized, are given less money for doing the proper job. Another example: Why is a nursing facility which catherterizes for the purpose of controlling incontenence (making the older person a prisoner of the catheter) rewarded with a higher reimbursement than the facility that toilets someone six or eight times a day at immensely higher cost? Why does the system reward and pay more for a decubitis which is caused by confinement to bed rather than rewarding the facility that spends much more money to avoid decutitis?

". . . Quality of care relates to quality environment, to privacy, to social components of care, to rehabilitation, to residents being kept out of bed, to residents being taught to feed themselves, to walking as much as they can themselves. Quality of care is not (solely) measured by tube or I.V. feedings, or by turning people every two hours in bed.

"Residents within the long-term care facility become accustomed and trusting of the professional staff and should, if possible, be treated for acute and subacute illnesses within the institution by persons familiar to them and reassuring to them. Moving to a hospital for acute care is a trauma that few of the elderly can withstand. My point of view, therefore, is that we should have the capability within our long-term care facilities to care for the person with acute illness of stroke, heart attack, pneumonia . . . The long-term care facility should have this capability, not because it's less costly, but because it is what's best for the elderly."

The total amount expended for nursing home care may reach well over $20 billion by 1990. Of this amount, given current trends, upwards of 70 percent of nursing home dollars will also be public dollars. Although supplemental coverage insurance is becoming more and more available, its cost is also increasing and the role of pri-

vate insurance dollars in paying for nursing home care is miniscule. In addition, inflation had already forced the impaired elderly to turn to their own savings earlier and more often. The percentage of income going into savings is decreasing and elderly persons in retirement, with few exceptions, have not been able to save to a significant extent.[29] Inflation has, until very recently, decreased the value of those savings at an unprecedented rate.

Documentation about poverty for the aged has been extensive and varied. The current projections suggest that 14 to 17 percent of those 65 and over are under the poverty guidelines, but the percent near but above these guidelines is so extensive it is still not unreasonable to note that upwards of one-third to one-half of the older American population have severe financial difficulties. What is missing from poverty guideline reporting is the percent of the elderly population in need of outside financial assistance in order to receive long-term health care assistance such as provided by the nursing home.

FAMILIES WITH FRAIL ELDERLY MEMBERS: ADDED CRITICAL NOTES

The role of caregiver is fraught with multiple stress including marital conflict, declining caregiver health role, overload (other familial relationships and perceived communal role), outside employment and added expenses. The caregiver role has few guidelines and few transmitted caregiving skills.[30]

The move into a caregiver's home by a frail, dependent elderly person requires changes within the family which require flexibility and mediation toward positive resolvement. Competing demands by spouse and/or children make the family milieu often untenable.

It should also be recognized that elderly family abuse is difficult to glean, whether physical or verbal or financial, sometimes by the elderly and sometimes to the elderly. The caregiver role is invariably given by women-daughter, daughter-in-law, spouse. With one-half the women already employed full time, the caretaker pool diminishes. With the increase in age by spouse and adult children, the pool will further diminish. With the nursing home becoming an accepted part of community resources, the reluctance to utilize this type facility will diminish.

Encouragement to caregiver roles is to be made through financial enticement such as payment for service given. This has both assets and liabilities. It will add somewhat to the caregiver pool, albeit with impact on nursing home admission an unknown, allow for some elderly to remain longer than otherwise in a home-like atmosphere but also develop an added hierarchy of governmental bureaucracy. Yet, if we are seeking additional answers to the care of the frail, elderly dependent person within a family this has sufficient potential to explore its feasibility.

Government and community, if it is to serve well the family and the frail, elderly dependent should reflect the following sensitities:

(1) The frail, elderly are persons of ontological stature equal to all the rest of us.

(2) Social policy regarding the frail, dependent elderly including allocations and services, is adequately framed and oriented only when it is cognizant of their personal worth within the collective needs of the body politic.

(3) Public policy regarding the aged, including allocations and services, needs to be comprehensive, adequate, unified, and facilitated, geared not to separable categorical needs but to separable categories of persons defined in terms of uniquely related needs.

(4) Home and neighborhood is one's primary habitat, the cultural setting affecting individual worth; the first and mandatory focus, then, for assistance, care and support.

(5) Alternative treatment forms are alternatives, then, to home forms, rather than vice versa, and the ample and suitable provision and application of alternatives humanely follows on their free choice and/or real need rather than by the imposition of tradition or vested interests

Thus, all developed services which maintain the frail, elderly dependent in their own habitat must be absolutely maximized before the rush of nursing home beds become a crescendo. Further construction of new beds or conversion of acute beds to long-term care beds must be subservient to the maximization of the preventive, ameliorative and rehabilitative elderly services allowing for in-home living. In and out patient geographic geriatric rehabilitation centers is a major tool toward this end as witnessed by the close to 70 percent rate of return to independent living by

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[29] Morrison, M. H. Planning for Income Adequacy in Retirement: The expectations of current workers. The Gerontologist, 1976, 16, 538-543.

[30] Getzel, G. S. "Social Work with Family Caregivers." Social Casework, 1981, 61, 201-209.

the Geriatric Center of Mansfield Memorial Homes. On the other hand, whether or not it is realistic to be able to keep a frail, elderly dependent person at home guided by family and assisted by other services requires a realistic assessment of the wishes of the elderly person and the capacity of the family to perform.

Health care costs are controllable. Prudent management is a key. Of even greater concern is whether or not we are desirous of continuing to look upon the frail, elderly dependent as humans and recognize dependency is a cost. As noted by Kant, "Man . . . exists as an end in himself, not merely as a means for arbitrary use by this or that will . . ."

Long-term care costs must ne measured against human need. They are readily controllable when the frail, elderly dependent are looked upon as less than human and when available families are called upon to serve beyond the capacities and strengths of the family.

Senator GLENN. Anna, we are glad to have you with us. She's director of the Cleveland Department on Aging, has been there since 1971, when the Cleveland Commission on Aging was created. Under her leadership the agency has developed several nationally recognized model programs, including one of the first home care projects.

And earlier this year Anna was elected president of the National Council on the Aging [NCOA], certainly well known in the field of leading organizations. In fact, Anna and I go back a long way. She testified at the very first hearing that I ever conducted outside of Washington, DC, back in 1977 in Cleveland, and I very much appreciated her help and her friendship through the years. I remember that hearing very, very well, because it dealt exactly in some of these areas that Dr. Kaplan says he's not sure are cost efficient when administered at home. And so perhaps you can comment directly on that because her innovative ideas have been in this area of how to serve the elderly in their homes, in the communities, in the blocks without displacing people out of their homes unless that absolutely becomes necessary. So, Anna, we look forward to hearing your statement.

STATEMENT OF ANNA V. BROWN, EXECUTIVE DIRECTOR, DEPARTMENT OF AGING, CITY OF CLEVELAND, OH

Mrs. BROWN. Thank you, Senator Glenn, I'm sure that you are so astute that you don't believe everything that you hear.

I'm indeed glad to be here for this hearing, and I appreciate your invitation from you, sir.

I'm going to read my prepared statement, and then there are some things that I really think I need to say to this audience this afternoon; things that are rather deep in my heart and my feeling about the future of older persons, not only in Ohio, but certainly Ohio being a part of the greater Nation, I have some things that I want to share.

As a society we are likely to extol the variety of our organizational efforts to provide for the aids to improvements to the quality of life for our people. Those service providing agencies represent expertise, and historical commitment which over our history has greatly unified the concept of community responsibility.

The timeliness of this hearing, Senator, is highlighted by a current united way effort. And during the last several years by slogan and volunteer effort, the community responsibility has been heroically supported in spite of a wobbly sick economy.

The separation of private skill/public efforts sometimes lacking coordination, or communication has led to suspension, competition and overkill in our efforts to meet and serve our people. However, the idea of public skill/private partnership is now almost 15 years online here in Ohio. In fact, the concept has been operational since 1971, for in that year we saw the first such alliance in those who came together to plan, implement and expand the capacity to serve the elderly in the model project in Cleveland known as One-hundred By One-hundred.

Here already established agencies with unprecedented commitment to city government leadership came together to develop the comprehensive network of their services to better serve older people. To the credit of the professionals, hard decisions were made. Duplicate services, over response, poor distribution of services were addressed, with community based agencies voluntarily withdrawing services when the mix for a given target group was over worked by the agencies with the same focus or same program. They learned to talk together to plan for the overall meeting of needs.

One-hundred By One-hundred as a model went online and was the prototype of the 680 area agencies on aging which cover the country, at this time. The major needs of older persons were the program focus of the agencies under contract for the delivery of the services.

I would say, Senator Glenn, if you have apprehension about your mother, all you have to do is get in touch with area agencies across this country and we can take care of anybody.

The changes in emphasis in aging are swift. Certainly those changes have been in response to the general economy and the country. The escalation of the old, old population growth, and governmental policies which reflect lately a bottom line money concern while scapegoating the medical and scientific technology which, if examined, says we are over producing too many old people.

Senator GLENN. The alternative to that isn't too good.

Mrs. BROWN. I don't think so either.

The General Accounting Office is to be commended for the study of the "well-being of old people in Cleveland." Out of the GAO study, we found that old people turned to relatives, friends, neighbors before turning to agencies in time of need, stress or emergencies. The GAO study is a landmark in the evolution of programmatic responses to the needs of old people. Bear in mind that the focus continues against institutionalizing which we discussed some 6 or 7 years ago at another hearing called by you, Senator.

What seems to be evolving is a combination of the natural support for old persons. Their families, who have provided 80 percent of the care now given older people, and those agencies which can provide services of more sophisticated disciplines.

Certainly the changes in the life style, education, career choice of women will have a great impact on how we will be able to continue that great family input to the composite effort to provide those caring services to the old.

Women have gone to work. Representing better than 50 percent of the work force. The care givers are not available, and while our

concern is the loss of the care givers for the old, there is likewise the care of our young children out of their homes, with too many stories of abuse, sexual and otherwise, being perpetrated on our young.

To meet the challenges of reducing health costs, providing surveillance over an older population, the Department of Aging, City of Cleveland, convened what has become a model for our consideration, another public-private cooperative effort called golden age out-reach for help, incorporated, which has trained older persons in a curriculum developed by the Case Western Reserve Medical staff, Clement Family Care Center, and Chronic Illness Center. The manpower for the program are stipened volunteers, each from their own street of residence. We have used the neighbor, found in the GOA study. Family and friends may not be nearby but the neighbor by definition is there. The experience of the GAO staff show older persons who need help are not so much in need of medical care as they just really need help.

The model is in Fairfax neighborhood in Cleveland where we have 3,000 old black people at poverty and below, but there are 87 percent homeownership. We have a small professional staff, only five. But there are 29 volunteers who are stipened who serve 1,700 enrollees of the program. The thrust of the program being preventive health care, early intervention to short circuit that march to the acute care hospital where the greater health care costs are. What GAO addresses is needs of a basically female population, in need of transportation, shopping trips, assistance with personal care, respite care and shared housing.

GAO acts as the broker for chore services, matching those with skills willing to work for small fees and the elderly who can afford those fees. The GAO model exemplifies the coming combination of public-private, coalition, self help design for service programs for the elderly, emphasizing the use of older persons who are hardy as the provider of services to their own peers who may be frail or impaired.

The preponderance of females in the target population precluded the use of any males in the Street Health Worker Corps, men being rejected entirely in that role, even to serve older men.

And, incidentally, when you say that older men are married, yes, they are; because they have to have someone to take care of them. Your women, the women are independent and know how to take care of themselves basically. But a man can't find his socks for example. They are spoiled. Can't unspoil them.

The new women who are growing older will be better educated, more knowledgeable in the affairs of government, commerce and education. She may have been an executive, perhaps married, but not necessarily, with or without children. The delayed start of becoming a parent in exchange for progress in a career may, over time present new problems.

The relationship of the older parent to a younger child in later years can hold problems leading to frustration and stress. And today we heard Congresswoman Oakar mention that we are not sure of the source of the abuse. I would submit to you that there is a reentry problem when older parents have an old child move back home because of widowhood, divorce, or whatever, there is a re-

entry problem. And here is the man who can tell you about reentry problems.

Senator GLENN. Only one wife, Anna, so far.

Mrs. BROWN. The housing problems of older women will be best addressed in congregate settings. Shared housing is somewhat questionable. The Chinese—and all respect to the Chinese, and this is no political talk—the Chinese symbol of war being two women in the kitchen.

The fact that 16.6 million elderly women bear the adversities of poverty and neglect in this country should encourage advocates for elderly not to lose hope and paralyze the continuing efforts to improvement of the quality of life for the nations older women. The number of older women has increased with a marked increase in the very old and the frail. More older women are living alone, and while the later generations have better paying jobs and benefits, will fare better in their later years, little progress has been made for 2.6 million who live below the poverty line.

Thirteen million women have no pensions, 1.7 million older women who are unmarried have only social security as a source of income. Some specific statistics which are of interest to us all. Six out of ten Americans over 65, and 7 out of 10 over 85 are women. I won't go into that. You've heard that all day long. These facts have to be paired with late figures of the world. Family members who traditionally have been the care givers. Of the care givers, 53 percent of the women are working.

Decades ago, only 38 percent were employed outside the home. In the Conference Board's recent study, "Working Women," it is noted that 60 percent of all family income is in households where wives are working. With the increase in working opportunities there is an outstanding increase in professionals. What does this mean. Care givers are the heart of the picture. The incidences of crime perpetrated on older women living alone is a very real jeopardy, making for anxiety and stress. Further, for the last survivor what obligations do communities assume in the way of support for the elderly, alone women. What agency provides legal services, who protects the lone older woman's interest in the sale and/or transmittal of real property.

There are populations for whom little in the way of support services have been initiated. The rural areas lacking services pose a bleak old age for many.

And I want you to hear that loud and clear in Ohio because we are basically a rural State.

Problems of foreclosures, real and contrived, have dispossessed many older rural Americans. Family farms are shockingly in decrease in total numbers. Black-owned farm acreage has been lost to developers, speculators and con artists, more often than not. Those dispossessed are old. We have not made a master strategy for rural older Americans yet.

What is more, there is the sorrowful plight of the migratory farmworker whose family is a living sacrifice on behalf of America's breadbasket.

What happens to the older migratory farmworker? Where does old age catch up with them?

In closing, we have some current concerns which we feel the Senate special committee should address. First, we think that protection of women, all women, should be protected under some pension plan if their husbands have worked or they have worked.

Recently we were in Washington for a meeting of the National Health Council. And Senator, this is a very serious, serious problem on the matter of eligibility for organ transplants. It's now an age eligibility argument that we are listening to. We will not give any organ transplants past the age 45. If you are going to live to 90, you are going to have either 45 years of discomfort or 45 years of pleading to somebody to take you to a dialysis center perhaps.

There are also age eligibility for hip replacement. They are saying in the medical profession they don't want to do a hip replacement until you're 65 because the hip replacement usually lasts 10 years and by 10 years you might be dead. No one mentioned that if you were 75 and you were going hail and hardy that you may want a second hip replacement to last you until you were 85.

Further, in the matter of the cost of living for older persons, I am always fascinated by the commodities market and the futures and all of that. We regulate everything or we deregulate everything, but I never heard of anyone ever looking into what happens on the commodities market. And the reason I got interested in the commodities market, I read once in the paper that a man in Sumatra bought up all the black pepper and I went to the market and bought myself two big boxes of black pepper. And the man at the cashiers office said to me, "Why are you buying all that black pepper?

I said, "In 6 months you are going to raise the price, and I won't be able to buy it."

I am also interested in the endentulous condition of our older population; 50 percent of older Americans either have no teeth or those that they have don't fit. And this is hardly conducive to the good nutrition that we are giving to them in those meal sites. And incidentally, with regard to the meal sites, the Commissioner on Aging testified before the hearing on the Older Americans Act, that the contributions, the voluntary—and that's in quotes,—"voluntary contributions were up this year, which proves that older Americans are better off."

I submit to you, sir, that we have had a change of the people who are coming to the meal sites in very great numbers. And I don't know how voluntary it is when somebody says, "Have you put something in the box?" But I do know that people are stretching what they do have left in resources by going for that one meal, and now the very poor older people who would be embarrassed to not be able to put something in the box are now showing up in the soup kitchens in this State, and I think that needs looking at.

I think we ought to look at the death benefit and how that was changed about on Social Security because we have 85 and 90 year old people who are dying and they are leaving 65 year old children who will have to scrape together to give a decent burial. And we've taken away that lump sum except for the spouse, and we have heard all day that spouse is already dead. Those children need to be reimbursed.

And what's more, we have people who are sharing houses with older people that—a woman called my office the other day, and you must realize that in America there are some people for whom the funeral is the finest thing that has ever happened to them. They had the prettiest dress and the most made over them ever in their lives when they are buried. And they want that $1,500 or whatever to put themselves away nicely.

And a woman complained to me in Cleveland, OH, that someone who boarded with her died without any insurance, she could not pull down 245 from any kind of benefit. The city of Cleveland furnishes you a box and a sheet. And she was in tears, almost hysterical, to put her old friend in Potter's field that way. Americans don't like to do that, and I know it. And I want you to do something about that please, Senator.

We talked about all these educating things. And I think education is great, I want us to do these things, we want to get these editors and these TV people and everybody into what we are talking about. But I want us especially out of the Department of Agriculture to do more nutrition education, especially the business of promoting calcium intake. That ought to help the dairy farmers. And ask these people to promote the use of milk, to promote the use of milk and cheeses so that the bone mass of women will be kept intact and osteoporosis and hip fractures will not cost Federal economy $2 billion a year for repair. That's a civic thing and I think we ought to promote it not only for older people but you grandmothers and great-grandmothers begin to tell your teenage granddaughters to do the same thing throughout their lives and they will be better off.

The whole incorporating of nursing homes is a problem that I see getting to be very serious in this country. The bottom line is profit for the stockholders. I hope somebody in Ohio will be brave enough to come up to some of these chain lines that are beginning to infiltrate our borders and say that why don't you be like McDonald's and franchise them locally, and let us have a board of governors so that the quality of care can be guaranteed. I would like to see someone brave enough to do that.

In the matter of what Medicare will or will not pay for, you know, if you lose a limb and you cannot pay for a prosthesis, and incidentally, a prosthesis costs thousands of dollars, then there are special stockings and straps and things that cost $50 a wack, a sock that costs $7, $12, there ought to be some kind of graduation where there would be some help on that so that people would not necessarily be incapacitated.

The matter of how we educate people in the use of taking drugs is an important matter that the Senate special committee can look at. Some of our older people think if they doctor with one doctor it is fine, but two doctors is better, and they will get the same diagnosis and doubling up on the same medicine. Sometimes we are saying they are balmy, when, in fact, they are just over medicated. So therefore we need to do some of those things that can be done to add to the quality of life without spending a lot of money.

Now, we talked about educating. Let's put it all in simple language so that anybody can understand. Let's get our brochures out in plain English and let us not forget the Hispanic, and let us not

forget the Polish, and the Italian, and the Hungarian, and all of those in that age group who are not necessarily bilingual. That is a simple thing to do, and we should do it.

Finally, sir, we look at the DRG, the diagnostic related groups, that admit people to hospitals. We are beginning to get stories in the country that people are going home before they should because the margin of profit for our hospitals is whether the patient stays the full length of the Government's allowance. And if they go home earlier than that, the difference is in the pocket of the hospital. I'm submitting to you that we are beginning to hear that people are sent home and are readmitted, and on readmission, they are being examined again with the same set of tests. And you are going to have a double billing on the test, sir. So I can't see that it's going to be very cost saving.

Finally. Finally I ask Dr. Butler, I'm sorry he isn't here, but some years ago we were entertaining some people from the Scandinavian nations prior to the White House Conference on Aging, and they were talking about the fact that aging is growing around the world, the population in the Carribean is doubling in a very few years. Old people are everywhere on this globe. My question to Dr. Butler was, has anyone thought about the military liability of having a lot of people who are elderly, so many of them frail, in the confines of countries who are rattling swords, who are not willing to sit down and talk and negotiate. I assure you, sir, no older person in America wants to walk down the streets of Columbus with their flesh in threads hanging from their bones, and neither do I plan to meet you on Public Square in Cleveland with my eye balls in my hand. [Applause.]

Senator GLENN. Thank you Anna, very, very much, I think.

You've given us a good list to look at. Quite seriously I'm not making light of your last point—what happens if we ever get into some kind of exchanges like that is almost too horrible to contemplate. I have a military background of some 23 years, went through a couple of wars, and I've seen people die, and I don't want to see any more die. That is one reason why when I first got to the Senate, I started working on that problem even though it was sort of abstract and it resulted in the Nuclear Nonproliferation Act of 1978, of which I am principal author.

And I'm sorry the last two administrations—I get very excited about this, this one and the previous being bipartisan—have not lived up to our wants in that Nuclear Nonproliferation Act. I think that is a tragedy. I share your views on that. I still work on that almost every day. In the office we are looking into some of those problems, why we can't get on with arms control negotiations, and I'm not saying just that this administration, it applies to the last administration, also. So I think we should be pushing for it, and I want it to be verifiable. We can do those things if we just get on with it, it can make a lot of us dead before we ever get old, so maybe it does fit in an aging hearing after all.

But Anna, you and I have both mentioned the hearing back in Cleveland in 1977, and you mentioned the GAO report, the General Accounting Office report. The care being given to the elderly in Cleveland, their study centered in Cleveland and those living in their homes and communities. The purpose of that hearing was to

follow up on the GAO study, and it discussed some 23 Federal programs. It pointed out, as I recall, 134 different programs through which assistance was being provided, and Cleveland had been doing quite a lot to help the elderly.

You played a very major leadership role in those innovative programs. Was there any one thing that you did, or how you set out to get community participation, because if we want to set up an ideal way of taking care of the aging, it would be OK for families to take care of families. Well, that doesn't happen. About 75 or 80 percent of the help for the elderly does come from families, but that leaves 20 percent of the people who are in deep, deep trouble. They need help. Well then you say we'd like to have local help.

Well, sometimes that works and sometimes that doesn't. Then we'd like to have State help or Federal help or a combination of all of these things. Now, you've been successful putting together community programs in Cleveland. Can you give us any advice that you can pass along to other communities as to how you do this, or how do you get community participation?

Mrs. BROWN. For one thing, I think necessity, I had no money, and you had to put it together if you were going to get it off the ground. First, we only had a very small grant to start. But I looked around to everything that was already operating and I began to make friends and linkages and bridges, and I do business with anybody who wants to do something for old folks. If it is a bottling company, fine, what have you got, yes, take it, anything.

I also do business with the utilities. We have a great program in the survival of older people called keep the lid on. We parley a lot of our programs on other people's bad images and then they get a rate increase down here in Columbus at the PUCO, and I have an idea that old people are going to be cold and I've been researching hypothermia for 5 years and find out that 25 to 40 percent of your body's own heat goes out through the top of your head.

You can believe that I'm going to call east Ohio and say, "I know how to make you look good and smell like a rose. Come over here and let me tell you what I want you to do for old people in Cleveland by way of educating," and we've given out for 2 years now over 1,000 knitted hats for old people to wear.

We had Cleveland Electric Illuminating Co. come up and do a new pin with a logo with a little man saying, "Keep the lid on." We made Blue Cross-Blue Shield give us a survival brochure, 140,000 of them in all the major languages. We gave the pins out through the school system, 40,000 children went home with that on. But the important thing is 10 American cities this winter are going to do that program under the auspices of the American Gas Association. Now, that is what I'm talking about.

Now, to get them together, Senator, I have turf problems. Some of my people sitting right here if they have turf problems, I have two tables in my conference room. If they are hostile, don't speak to each other, can't stand the sight of each other, I use the small table. Then the elbows have to rub, have to look right into each other's eyes. And I let them know that neutral ground is right where I'm sitting. And if they have turf problems they'd better go now, and nobody ever goes, and therefore we get the job done.

But we make a mixture of public-private schools, churches. Somebody's giving me 1,000 blankets for old people on the kick-off day for keep the lid on. It's easily done, if we make the linkages. If we know what the resources are. If we tell somebody with enthusiasm what it is we want to do, and we can get it done. The GOH project is five agencies all well established, they formed themselves into a nonprofit.

Well, we didn't want to make any one Cleveland agency pay for it, so we made also a consortium of funding sources. Remember that model project that uses a street health worker on each street in their neighborhood to give surveillance to that population, all the money for that was raised in the city of Cleveland. There isn't one dime of Federal money. We have a small grant from the State of Ohio and a little community block grant money, but we did not write to AoA for any money.

Senator GLENN. I have another suggestion for a program like this is to have a Brown in every community. [Applause.]

Dr. Kaplan one of your comments about the home care and whether, you used as example, hip fracture, and I would agree, you are not going to save any money if you have a hip fracture or something like that. But short of that where people just need help getting around, or somebody to help them up and down steps, or something where they have difficulty taking medicine, or a shot that they have to take daily, don't you feel that that is far less expensive, of course, than putting people into an institution?

I wasn't quite sure what you were referring to in your last comment before your close.

Dr. KAPLAN. Beyond any question, Senator, the type of services you are mentioning now are those which readily can be shown to be of a considerably lesser cost than institutional care. The type that I was referring to were those that required a vast amount and array of home services of a much more sophisticated nature, as well as the recognition that the stress upon the family and possibly the older patient continues to grow. This would result in a greater than necessary cost to society by allowing the older person to remain at home.

Senator GLENN. Ella, one thing of difficulty for both men and women, but I guess it applies, hits women more harshly than the men really, is the pension portability. You mentioned that one.

Ms. HOLLY. Right.

Senator GLENN. Many people get aced out of pensions, if the man dies early, women are doubly aced out of that pension.

Do you have any ideas on that? We've worked some on that at the Federal level, but not enough, I admit. Because too often pension portability, which if you're working one job and had a pension being partially built up, and then maybe either you lost that job, or the industry went out of existence, you don't have a fully funded pension, or even if you did have a funded pension and then the business goes down, there is nothing to pay the pension, so if you go work in a different industry then the original pension credits don't apply to the second job. You end up having worked your whole life with no pension when you thought you were getting it. So it's been suggested in the past that perhaps some pensions should be paid into a national pension fund of some kind where it

is guaranteed, or there is a pension insurance guaranteed in case the steel industry goes down or up or whatever, and the pension, the ability of the company to pay the pension to the people who thought they were going to get it, is therefore guaranteed through some sort of insurance system. We don't have that now.

Do you have any thoughts as to how this could work? Do you think we need something like that?

Ms. HOLLY. We desparately need something to change the current pension situation. Another thing we need is an educational process where people can get information about their pension plans so they can make appropriate decisions. At this point, many of the women who do have pension plans, do not understand the legalities of that plan. They really don't have any idea of the scope or context of the plan. A basic problem is that the plan is often written in Nanoo Nanoo, By that, I mean a foreign language which needs to be interpreted for clear understanding.

Senator GLENN. Whereases and wherefores, most of them.

Ms. HOLLY. As a result most individuals really don't have an idea of what options are available. As a result they can't become advocates for change, instead they are kept in the dark about the pension process. So along with legislative reform, we also need some type of educational arm that is reaching out to both women and men, making them aware of the key pension issues. We all need to understand the how-to's of a pension plan so that they can become more involved throughout the process. It should be a process where the pension is working for the people, not the people working for the pension. We need to turn the process around and get the common lay person involved in not only pension reform but the entire development of pension plans.

Senator GLENN. I think we need a lot of work in that area. And Dr. Atchley, I'm just going to call on you, because you mentioned the same thing, pension laws and portability and pension waiver requirements, there should be for spouses who don't know what the pension was of their mate.

Dr. ATCHLEY. Right.

Senator GLENN. And get aced out of that, and spousal rights, and you raised quite a number of very good points in your earlier comments. Would you want to comment on that?

Dr. ATCHLEY. One thing that I've always tried to stress is the fact that people can't plan for anything unless they know what their situation is. I wrote a paper a number of years ago for the other Aging Committee—a report on mid-life women—on retirement planning for women. In that report, I tried to think of—of some ways we could deliver the message to working women in America that they need to get into retirement planning, they need to conceptualize what their social security is going to look like, what their pension is going to be like, if any, that sort of thing.

Another aspect of all this goes back to making pensions work for the people who earned them. Right now, some corporations are treating the money that pension funds earn over and above what it takes to pay current pensions as the corporation's money, when in fact it is employees' deferred wages. Then, instead of using these funds to increase the size of the pensions that are being paid, the companies are siphoning that money off and using it as if it were

their capital. This is a questionable practice that ought to be looked at.

Senator GLENN. Thank you, Doctor.

Dr. Seltzer, I know you have a number of questions here.

Dr. SELTZER. I think one of the major questions I have is in relation to intergenerational tensions and feeling because what I heard Mrs. North talk about this morning was some of the concerns the younger generation have about Social Security. And what I've heard some of you talking about is some of the high cost of medical care for older people, what does this mean for the society in general.

I would be interested in getting some reaction from the panel about how to let people know that this is not an either or proposition; that there is enough for all people; that you don't play one generation off against the other because I think that's very dangerous.

Dr. ATCHLEY. I'm willing to take that one on a little bit. The way I look at it is this: The Social Security agreement is between the individual who contributes to the system and the U.S. Government. The individual pays FICA throughout his or her working life, and then when it comes time to exercise the retirement pension entitlement, it's up to you, Mr. or Ms. U.S. Government, to live up to your end of the bargain, and where you get the money is up to you.

I look upon Social Security and disability benefits and all of the social insurance aspects of our Government as IOU's that people are entitled to because they've earned them. I don't call that dependency. When I collect my bond from the bank and cash it in, I don't call myself dependent or burdensome or any other damned thing.

Senator GLENN. Let me comment on that just very briefly. I'm not here to defend the Federal Government or Social Security benefits. Nonetheless, one of the difficulties that came up in discussing Social Security is that through the years, we've tacked enough things on to Social Security, and good things, and I've supported them, but there are enough good things that for the average person receiving Social Security they get back roughly three times what they paid in over the rest of their life on the average for the Nation.

So it is meant that what was paid in is not sufficient to pay the bills on what's going out. That plus the fact as we've had multiple, multiple statements here today, people are living longer, they are if they're beyond 65 years, much longer than anybody ever anticipated back when the original studies were done. And so that's what really put Social Security in a bind, and what caused the semicrisis here a couple of years ago where we went through a year long study to try and determine how are we going to take care of that. They didn't want to cut back on someone's benefits. Most of them are very good, and didn't want to cut back, people jumped up and down, and people didn't want them cut back. And yet we had to figure out how to fund them because they had gone, in fact, tripled the amount that's being paid in during the working years.

So it is a problem from the Government's side, too. It's not a matter of just paying in and getting back just what you paid in. If that was the case, it would be very, very simple. But we've put cost

of living on this, and so on, through the years. So we're keeping up the pace with people that want that same kind of buying power, the same kind of protection. We are keeping pace with it, and I agree with you, this is some kind of contract between the people and their Government, and we can operate faith with the people and their Government.

I want to make just a brief comment here, some administrative matters, and then close with a very short statement. I would like to remind you to leave these yellow sheets, if you would please, on the lobby tables or hand them to one of the staff members here. If you don't have specific comments, we'd appreciate having your name and address, at least, so we can let you know of our future hearing and also of some of the publications the Aging Committee sends out on a regular basis. There is a box in the lobby, I believe, that is provided for these sheets to go in.

I want to thank you all very much for coming today on such a lousy weather day. In bringing this hearing to a close, I'd first and foremost like to thank our witnesses very, very much, for they presented us with what I believe is an extremely accurate profile of women in our aging society. The portrait that they've painted is very different from the one that most of us envision when we think about what it's like to grow old in America. And what most of us have in mind is very much like a Norman Rockwell painting, a wife and retired husband, they live in a home they own in good health among the flowers and the trees surrounded by their loving children and grandchildren. But we've heard today that for far too many women growing old means being poor, being alone, and being largely dependent not on yourself, on your own resources, but on someone else.

How has this happened? Why is it that the dream of growing old in comfort has become a nightmare for so many American women? How can we, as a people, as a nation reverse this trend and shape a brighter future. Today's hearing has demonstrated that these questions cannot be answered in a single day, but I also believe that today's hearing has been a major step in the right direction. We've had some excellent testimony today, and I would add that I would like to submit questions to you in detail, since our time ran so short today. We did not have the time for adequate questions. We would like to be able to submit questions to you and have a reply that we can include in the committee record, if you would be so kind.

But it has helped us to identify so many of the issues that must be addressed. It has shown us that the current programs and policies are not doing the job that must be done. It has pointed us toward some of the changes that must be made if the younger women of today are to have a happier and more secure tomorrow than many of the elderly women have now. I think the need for looking into this further is very, very clear. It is my intention to conduct such hearings beginning in early 1985, and I would announce that intention today.

As the senior Democratic member of the Senate's Special Committee on Aging, I look forward to examining these issues in greater detail, especially those relating to health care, to work and retirement policy, and to family and community life. And now, how-

ever, I want to thank you, the audience for coming to today's hearing, and I want to reiterate my willingness to hear your comments on issues. Meeting these challenges is going to require the best of all of us. These are not simple questions to answer. No one person or institution can solve that alone.

So I look forward to your future participation, and I leave here today secure in the belief that with the wisdom of age, and the freshness of youth, we Americans will, indeed, build a future that is worthy of our past.

Thank you and God bless you all. The hearing is now adjourned.

[Whereupon at 4 p.m. the hearing was adjourned.]

APPENDIXES

Appendix 1

QUESTIONS TO WITNESSES FROM SENATOR JOHN GLENN

QUESTIONS TO ROBERT N. BUTLER, M.D.

Senator GLENN. I was interested in your comments about the importance of aging research and certainly see the merits of a multidisciplinary approach—or looking at all of the underlying changes that occur with aging—compared to focusing on one disease at a time. I support the efforts of the National Institute on Aging and agree that additional funding is warranted.

However, I would also be interested in your opinion—this is something I have asked others—about whether there are diseases or conditions (i.e., arthritis, diabetes) where we are close to a major breakthrough, which could be accomplished if we only had an infusion of additional research dollars?

Where would you target additional biomedical research dollars? By finding the cause and cure for which diseases or conditions would we make the biggest impact—in both human terms and on health care expenditures?

Dr. BUTLER. I would target additional biomedical research dollars on the biological mechanisms of aging, specifically the molecular biology of aging. We can begin to understand the underlying mechanisms that enhance the susceptibility to the diseases, conditions and disabilities of old age. We would affect a broad range of suffering people. We would enhance the quality of old age, would help reduce the social costs, and help reduce self care expenditures. Along a similar vein I would add to this targeted additional biomedical research dollars on neurobiology, cancerbiology, and especially the "new biology" as reflected in recombinant DNA and hybridoma technologies. It is sad that at this moment when the opportunities for exponential growth in understanding of human health and disease there is such fiscal constraint. I can only hope that we are not penny-wise and dollar foolish.

Senator GLENN. Osteoporosis is a disease process involving thinning of the bones. It is especially common in elderly women. Hip fractures often result in death or extended periods of rehabilitation, chronic impairment, or nursing care. Current evidence suggest that osteoporosis may be preventable by increasing calcium and fluoride intake, and by using post-menopausal estrogen therapy.

What progress has been made in treating osteoporosis, and can today's younger and middle-aged women take steps now to prevent this condition in their later years?

Should physicians encourage nutritional changes for women now to avoid the disease later? How widespread is the prescription of estrogen therapy by doctors? What is the role of public education of middle-aged and younger women?

Dr. BUTLER. Today's younger and middle aged women can take steps to prevent osteoporosis in the later years. We believe the condition is in some ways preventable through daily calcium (some 1,000 grams a day of calcium carbonate or its dietary equivalents), the avoidance of high phosphate in sodapop drinks (which help reduce calcium in bone), the elimination of tobacco intake, moderation of alcohol intake, and the maintenance of physical exercise to promote bone density. These are among the important health habits that can prevent osteoporosis.

Doctors should play a major role in encouraging good nutritional habits in women. Public education should focus on this topic.

The issue of estrogen is more complex. In the absence of family histories of cancer it is probably indicated to utilize estrogen at the time of the menopause as a preventative. Under those circumstances estrogen has therapeutic advantage once osteoporosis, in particular fractures, have occurred.

Senator GLENN. I remember our meeting—back in 1977—when you were Director of the National Institute on Aging and were hosting your counterparts from 11

countries who were here to discuss the research needs of nations faced with a growing aged population; and the changes in economic, social, and health care systems this necessitates.

There are countries that are ahead of us with respect to the aging of their populations, and countries where the elderly are treated differently than here in the United States.

Do you believe that an international dialogue is important and beneficial?

How much exchange is taking place between nations with regard to research findings about the aging process and about caring for an elderly population?

Dr. BUTLER. I remember with great pleasure our hearing that you helped lead in 1977 on "The Graying of Nations." This was during the period when I was Director of the National Institute on Aging. We can all learn from one another and some countries are moving very rapidly. Japan, for example, devotes 7 percent of its GNP to health care compared to 10 percent in our country and yet appears to do extremely well in the care of older people. It also has an important research institute on aging. The Soviet Union has an active research institute in Kiev. I do believe that international dialog is important and beneficial.

There will be an International Conference of Gerontology to be held in New York, July 12–17, 1985. The United States is the host, Dr. Ewald Busse, Professor at Duke University, is president. This would be a wonderful occasion for another set of hearings. The International Congress, itself, of course, provides an occasion for scientists of various nations to present research findings about the aging process and the care of elderly populations. What your hearings could do would be to help move the presentation of findings from a scientific arena into that of public policy, specifically, health science public policy and health care public policy.

Senator GLENN. The 1983 Social Security rescue package provides that the retirement age for full benefits will gradually increase to age 67 in the year 2027. Yet, women often must drop out of the work force before age 62 because of health problems and/or age discrimination.

Does this mean there could be a gap of several years between work income and retirement income? And what should we do to ensure economic security during this period?

Can research be done now, and throughout the coming years, to determine what will be the impact of this increase in the retirement age; and whether we need to take another look at this change, particularly if the Social Security trust funds are in good shape?

Dr. BUTLER. Your question regarding the potential gap between working income and retirement income that would result from the gradually phased increased age of eligibility of Social Security is an extremely important one.

For your own information and for reference purposes I am enclosing a copy [1] of an article based upon testimony which I was requested to give as Director of the National Institute on Aging by Alan Greenspan, then Chairman of the President's Commission on Social Security Reform. It makes clear my concern over such a gap as it affects men as well as women.

Unfortunately, we do not have effective measures of individual function. We have not invested adequately in longitudinal studies in the United States. We do not know about human performance and how it changes with time. We can speak about populations by age in the aggregate but not on an individual basis.

We should rectify this by an appropriate investment in longitudinal studies. I would begin with the Baltimore Longitudinal Study on Aging of the National Institute on Aging so that there are enough personnel and funds to ensure that we can study at least 100 men and women for every decade of life throughout life. I think we should be supportive of longitudinal studies of various newly developed broadly based (gender, social economic status, race, ethnicity) samples in various institutions around the country. We must always study disease, of course, but we devote very little to studying success, effectiveness and toward development of understanding of normative aging.

QUESTIONS TO DR. MILDRED M. SELTZER

Senator GLENN. You mentioned the negative stereotypes that many doctors have about older patients.

Would additional training of health professionals who serve the elderly help this situation? I understand that of the 127 medical schools in our Nation, only 15 require courses in geriatric care and only 6 have affiliations with nursing homes.

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[1] Retained in committee files.

Also, do you think the increase in the number of women doctors makes a difference in the degree of respect and concern given to older women patients?

Dr. SELTZER. You wonder whether additional training of health professionals who serve the elderly would help combat the negative stereotypes that many doctors have about older patients. Certainly I think it would be extremely helpful if there were units on gerontology in medical schools. There is often some opposition to introducing additional curriculum material into what is already considered a highly compact program. I'm concerned that if courses are added to the medical school curriculum that they be taught by people who are aware of the basic data in the field of aging. This may mean that in some instances physicians would turn the teaching responsibility for the courses on typical aging over to other professional educators such as gerontologists.

I am not sure that the increase in the number of women doctors would make a difference in the degree of respect and concern given to older women patients. As I indicated at the hearing itself, it is not the gender of the professional person which makes the difference but rather the nature of the educational experience to which they are exposed. I do not think there is anything inherent in the fact that one is a woman that makes one necessarily treat other women more adequately and with greater concern.

Senator GLENN. You mentioned veterans in your testimony, and I'd like you to elaborate on that issue a bit. There has been a lot of attention recently to the need for the Veterans Administration and other agencies to plan for our growing male veteran population, because the number of aged male veterans will increase dramatically from 2.8 million in 1980 to 8.6 million in the year 2000.

But isn't it true that the number of women veterans is also growing? What can you tell us about this female veteran population, and is the VA taking this into consideration as they build medical facilities for the future?

Dr. SELTZER. There has been a tremendous amount of attention given to the growing veteran population. As I indicated at the hearing, I am concerned about the whole issue related to women veterans and the fact that the data about them is somewhat unclear. I think I mentioned that one of our graduate students has been gathering data on women veterans. I have asked Ms. Markey to attach to this letter some material concerning the topic of women veterans.

Senator GLENN. Now that so many women are in the work force, do you expect them to experience the same stresses about retirement that many men face—such as maintaining self-worth after retirement and filling their leisure time with meaningful activity?

Dr. SELTZER. The basic assumption in your question is that there is a great deal of stress associated with men's retirement. The data do not back this up. Most people expect to retire and look forward to retirement. In fact, the data show there has been a trend toward early retirement. Women, unless there are some special circumstances, may well feel the same way about retirement that men do. It is quite possible, however, that in instances where women are widows their work is an insulation against the loneliness of widowhood. In addition, because women's salaries throughout their lifetime have tended to be somewhat lower than men's, their retirement income is less. For this reason, women may experience some stress in retirement—it is not the retirement, however, that is causing the stress but rather the lower income. The vast majority of people manage to maintain considerable self worth after retirement and find plenty to do to occupy their time. Retirement is rarely a crisis for most people.

WOMEN VETERANS

(By Paula R. Markey, Graduate Student, Scripps Foundation Gerontology Center, Miami University)

The population of women veterans is growing and tends to be clustered into age categories: those 60 and over and those under 40. Compared to male veterans, little is known about these women. In fact, it is very difficult to even determine how many female veterans there are. Until 1982, when the results from the 1980 census were released, they were estimated to number 742,000 or 2.5 percent of the total veteran population. The census showed a much different approximation; it numbered female veterans at 1,218,000 or 4.3 percent of the veteran population. This is a discrepancy of almost half a million. Women veterans had never been counted before. Though information on male veterans has been included in every decennial census since 1910, female veterans were included for the first time in 1980. Besides actual numbers, very little is known about their demographic characteristics such

as geographic location, income and marital status. We know practically nothing about their educational, health or housing status. Our knowledge of their attitudes, beliefs, and values is nonexistent.

A major reason for this lack of descriptive data is that every large scale study or survey of the general veteran population has either ignored or excluded women. These include the Annual Current Population and National Institute of Health surveys, The National Veteran Survey (1977), the National Academy of Science Study (1977), and periodic special surveys by the Departments of Health and Human Services, Labor, and Personnel Management. The basis for ignoring women in these surveys was that they comprised less than 2 percent of the entire veteran population. Of course we now know that the estimated 2 percent figure was not correct.

Considering this situation, the VA has made progress in its approach to women veterans. Besides their inclusion in the 1980 census, women veterans have been the subject of at least five government reports. These include: Women Veterans: Use of Educational Benefits Under the GI Bill (September 1981), The Female Veteran Population: An Overview of its Growth in the Past Decade (March 1982), Actions Needed to Insure that Female Veterans Have Equal Access to VA Benefits (GAO Report, September 1982), and Women Veterans: Use of VA Hospitalization (August 1982). These reports pull together the information that currently exists. A basic flaw inherent in each of them is that their computations are based on precensus estimations of the total female population. The VA has also planned for a Harris poll on women veterans to be published in February 1985. This growing awareness of female veterans prompted the VA to create an Advisory Committee on Woman Veterans in 1983. Outside of the VA, there are some researchers focusing on women veterans. Among them is Dr. D'Ann Campbell of Indiana University who is doing an intensive study of World War II women.

Older women veterans (those age 60 and over) are estimated to number over one-half million. There is evidence that these women underutilize VA health benefits at higher rates than do other veterans, both younger women and men of all ages (GAO report, 1982). The report suggests that reasons for lower utilization include: lack of knowledge about which services they are entitled to, the lack of privacy in many VA hospitals, and the lack of specialized services for many of their health problems. The GAO Report brought these inequities to the attention of the VA and the VA has since included some remedies in five year construction and renovation plans. However, as of May 3, 1983 Robert Peterson of the GAO contends "Despite the actions VA has taken to address female needs in the vet centers, women still face problems gaining acceptance at some centers."

The VA has a great deal of information about older male veterans as is evidenced by the The Aging Veteran Report (August 8, 1984). This data is used in planning and organizing VA geriatrics and gerontology services. However, the same report has only one small section on the needs of women veterans. Without more detailed information about these women, it is doubtful that they will be served adequately in the future.

Questions to Dr. Robert C. Atchley

Senator Glenn. I support legislation to implement earnings sharing under Social Security and I am hopeful that this is an issue we will consider next year. As you know, earnings sharing is intended to improve coverage for both working women and homemakers by treating marriage as an equal partnership in computing Social Security benefits.

However, do you think we need to be concerned that implementation of an earnings sharing plan could provide equal benefits, but benefits that would be inadequate? I am thinking that if we enact a plan which does not increase anticipated Social Security outlays, that there will be some people who will get less in benefits as well as some who will receive more than they would under our current system.

Dr. Atchley. I am in favor of eliminating the spouse benefit and targeting Social Security benefits at 60 percent earnings replacement for all covered workers. As it stands now, earnings replacement is this good only for couples. Single people of both sexes suffer without the spouse benefit. Nonemployed married women who become divorced in midlife could be given an earnings credit equal to 50 percent of their husband's earnings for the years they were not employed. Since social security drops the 5 lowest years, they would have 5 years to get their own entitlement up to a decent level.

As long as Social Security benefits are tied to earnings there will always be inequities in the system. I have thought for a long time that people who are employed

35 or more hours for at least 9 months of the year over a period of 30 years or more should be entitled to at least the BLS low budget for an urban individual.

Since Social Security is mainly a retirement program, I believe it should remain tied to individual employment. This provides its legitimacy as an earned benefit.

In the case of women whose 50 percent spouse earnings credit and their own earnings generates a benefit below the BLS low budget, the difference could be financed from general revenues.

I appreciate your concern for not increasing taxes, but the fact is that compared to most other industrial countries, we are well below average in the percentage of tax we pay for retirement and old age income security. My proposals, if enacted, would increase the tax revenue requirements only a modest amount.

Senator GLENN. The 1983 Social Security rescue package provides that the retirement age for full benefits will gradually increase to age 67 in the year 2027. Yet, women must often drop out of the work force before age 62 because of health problems and/or age discrimination. Does this mean there could be a gap of several years between work income and retirement income? And what should we do to ensure economic security during this period?

Can research be done now, and throughout the coming years, to determine what will be the impact of this increase in the retirement age; and whether we need to take another look at this change, particularly, if the Social Security trust funds are in good shape?

Dr. ATCHLEY. Our research indicates that women who retire early are mostly middle and upper income married women and that nonmarried women with low incomes are the single most likely category to retire later than age 65. Nevertheless, we do need some sort of provision for women who become widowed prior to age 60 and have no prior employment. As long as the reduction in benefits is actuarial, there is no reason why survivors should wait until age 60. These benefits, though lowered would certainly provide desperately needed resources to some widows.

Senator GLENN. Although only 13 percent of today's older women receive private pension benefits, more middle-aged and younger women are becoming vested for pensions because of their increased work force participation. However, many women are still concentrated in jobs that do not provide pension coverage—small businesses, retail and service sector employment. And pension laws still favor the needs of higher-paid, continually-employed, full-time workers who are primarily men.

What changes are needed to make pension laws more equitable for all working women, and to encourage more employers to provide pension coverage?

Dr. ATCHLEY. The MUPS proposal recommended by the President's Commission on Pension Policy in 1981 would handle this problem.

Senator GLENN. As long as we do not provide equal pay for equal work, we will continue to see women having problems with inadequate retirement income, because Social Security and pension benefits are tied directly to wages. You recommend passage of pay equity legislation. How can we dispute the claims of opponents who argue that it is impossible to compare different jobs and establish their relative worth, and that it is not discrimination but the marketplace that determines wage rates?

Dr. ATCHLEY. Pay equity legislation already exists. It is enforcement that is lacking. As to the impossibility of comparing different jobs, surely all GS–13, step 2's are not alike, but they get the same pay. The fact is that many employers still see women as not being in the "economic provider" role and therefore not "needing" base salaries as high as men's.

Senator GLENN. Many middle-aged women encounter problems in the workplace due to age and sex discrimination. The Aging Committee has been involved in age discrimination legislation and oversight of the Equal Employment Opportunity Commission to make sure the age discrimination law is being enforced.

What should we be doing to make sure the agency addresses the needs of working women? Is the problem that EEOC is concentrating its enforcement work in other areas, or is it a problem due to lack of enough resources?

Dr. ATCHLEY. Some problems with EEOC are well known to your committee. These include performance standards for EEOC employees that provide incentives to stress cases involving large numbers of employees, large potential settlements, and government employers. These standards in themselves discriminate against women, who are more likely to work in small business and to encounter smaller wage losses due to lower wages. The main problem is lack of staff and the need to restrict drastically the number of cases taken to court by EEOC.

Senator GLENN. You mentioned the need to develop private long-term care insurance. Just a few weeks ago, we had an Aging Committee hearing in Washington on this issue. A main priority that came out of this hearing is the need to educate

people—to have a major public awareness program—because most people think they have much more coverage, for instance under Medicare, for long-term care services than they do have.

Do you agree that this is a problem? Do you have any suggestions?

Also, I would be interested in your views on what private long-term care insurance should cover? For instance, do you think it is important to include home health services?

What other options do you think should be explored for financing long-term care—I am thinking of home equity conversions, and long-term health care IRA's, which are talked about.

How can today's younger women prepare for the financing of their long-term health care needs? Are there any good options available now?

Dr. ATCHLEY. I agree that people need more education about what Medicare does and does not cover. The problem is that until people need to use a program's benefits, they tend not to pay much attention to its limitations or provisions. One advantage of getting private insurance companies involved would be their efforts to educate people on the need for private insurance. Incidentally, the Health Insurance Association's most recent report supports the need for long-term care insurance but concludes that Medicaid is a deterrent. This is a very misguided notion that indicates a need to educate the insurance industry as well as the public.

The need is for insurance that would provide financial support for both in-home and institutional care (both personal and health care). The most reasonable and practical goal is to provide a defined benefit (for example, $500 per month) that would slow down asset depletion for middle and upper-income older people.

There will always be people who will exhaust their resources, and I believe that anyone who depletes substantial savings and still needs long-term care should qualify for public protection under "catastrophic illness" protection.

QUESTIONS TO DR. JEROME KAPLAN

Senator GLENN. I was interested to learn of the geriatric center at Mansfield Memorial Homes, and of the high rate of return (70 percent) to independent living.

I would appreciate hearing a little more about the type of patients that benefit most from rehabilitation services, and how you are reimbursed for rehabilitation services.

Dr. KAPLAN. An analysis of our patients who return to independent living indicates that about 67 percent had fractured hips, 25 percent had a diagnosis of stroke, 5 percent amputees, and 3 percent included patients with arthritis, heart condition or other conditions.

Reimbursements are made from Medicare, Medicaid, Blue Cross, other private insurances, philanthropy, private resources of patients and/or their families in various combinations of these resources.

Our social service department spends most of the time trying to make these payment systems work on behalf of our patients. We find each system to be flawed in one way or another in terms of long-term care needs.

Medicare provides limited benefits, limited both in length and in coverage. It does not truly address long-term health care needs.

Medicaid provides longer term benefits than Medicare, but the reimbursement rates are many times below actual costs of care.

Private philanthropy ordinarily is in a position only to assist in an unusual and rare situation and then for a very short period.

Private insurance, for the most part, pays only with Medicare and stops when Medicare stops. There are a few policies which pay for an additional period following Medicare coverage. Again, this does not address long term care needs.

Finally, none of these approaches pays for long-term care at home where most older persons prefer to be.

Senator GLENN. Several weeks ago, we had an Aging Committee hearing in Washington on the issue of private long-term care insurance.

A main priority that came out of this hearing is the need to educate people—to have a major public awareness program—because most people think they have much more coverage, for instance under Medicare, for long-term care services than they do have.

Do you agree that this is a problem? Do you have any suggestions?

Also, I would be interested in your views on what private long-term care insurance should cover? For instance, do you think it is important to include home health services?

What other options do you think should be explored for financing long-term care—I am thinking of home equity conversions, and long-term care IRA's, which are talked about.

How can today's younger women prepare for the financing of their long-term health care needs? Are there any good options available now?

Dr. KAPLAN. I agree that most older persons have the expectation that Medicare plus their private insurance will provide all the coverage they need. They expect to get coverage under Medicare for 100 days and don't understand that this is the maximum possible number of days.

They also do not understand that most private insurance pays only with Medicare. When Medicare coverage stops, they learn then that their Medicare supplement stops also.

If longer care is needed (whether skilled care or intermediate care), the person is left with no resources except their own savings or their Social Security check to afford continuing nursing home care. They turn then to Medicaid after using up all their assets of impoverishing themselves to become eligible for Medicaid.

We all know that the hospital setting and the nursing home setting are more costly by the nature of their settings than care rendered in the person's home especially if the person's condition is such as to possibly be cared for at home through our known support structure. The public policy, as exemplified in both Medicare and Medicaid, has been to pay enormous sums to hospitals, lower sums to nursing homes, but a more limited amount to home health services and none at all to other community based care services, including day care, transportation, live-in homemakers and care service.

At this time private health insurance pays nothing for home health services, homemaker or day care services. The insurance industry might be persuaded that their funds might stretch further if these alternatives could be included in coverage.

It is difficult with health care costs to currently envisage any long-term care financing plan which can be carried out by individuals themselves over their working period. Employed women (and men) and their spouses should have options to be part of a vested health plan incorporating long-term care. I do not, at present, foresee individual movement by people.

Employers should be encouraged and given enticements to include long term care insurance coverage with their health coverage options and private insurance should also be given such enticement. I would further suggest all policies carry options and alternatives such as two-thirds payment of a hospital rate for a nursing home and other proportionate payments for home health care, day care, et al.

Senator GLENN. What do you think will be the impact of Medicare's prospective payment system (DRG's) on the types of patients needing nursing home care? If hospitals are trying to shorten patient's lengths-of-stay, I assume we will see more "heavier care" patients in nursing homes.

We had an Aging Committee hearing last week, and I think legitimate concerns are being expressed on both sides. Medicaid patients and others—particularly those requiring "heavy care"—are being discriminated against; and nursing home personnel are concerned about the quality of care they can provide given State Medicaid reimbursement rates, which they feel are too low—particularly to care for certain residents requiring "heavy care."

Would you please comment on this situation?

Dr. KAPLAN. We are already seeing some serious results of the DRG system, serious in terms of the quality of health care for acutely ill senior citizens.

Patients are admitted to our nursing home still needing hospital care. Incisions still have stitches, cardiac and diabetic conditions are not stabilized, patients are still weak from surgery. The average hospital stay of our patients has now dropped from 20 days to 11 days, in some cases as few as 7 days.

We are expected to do acute care nursing without the Medicare reimbursement reflecting the additional staff required. DRGs have filled the nursing home beds in the area and most have waiting lists. The home health agencies (nonprofit) are swamped by the numbers of elderly discharged directly to home. For profit home health agencies are coming into the field, but they take only paying customers, leaving indigent patients for the nonprofits and of course Medicaid does not pay for home care (in Ohio at least), so there are no answers to a system that puts DRG's into effect before sufficient home care services are available in the community.

We have more than one example of patients being discharged from hospital to home, alone, with no care-giver available, so that we believe there will be some deaths as a result of the DRG system. It is true that the Medicare and Medicaid reimbursement rates do not pay the actual cost of care so that we are both required to accept Medicaid patients and then accept payment at less than our cost. In the

long run, it appears the system is designed to create nursing home bankruptcies unless common sense regulations and procedures can be developed and implemented.

Another additional difficulty now presents itself when our Medicare intermediary tells us that Medicare claims for our extended care facility for fractured hip can no longer be paid by Medicare unless the patient is 50 percent weight bearing. Some of our patients are 50 percent weight bearing when they are admitted (those who receive an artificial hip joint). But others who receive a hip pinning or screw-plate fixation will not be 50 percent weight bearing for several additional weeks. Moving these patients home or to our less skilled section and then back to the skilled section after an x ray shows their weight bearing capacity makes little sense to us, in terms of the patient, the family or the source of payments for the interim period. Yet these are the regulations (grounded in cost control thinking, not "person" thinking) that we all have to work with.

Senator GLENN. You mentioned in your written testimony that no major breakthroughs in preventing chronic disease are imminent. This morning we heard Dr. Butler express support for aging research, which could be more beneficial than research concentrating on one disease.

I would be interested in your opinion—this is something I have asked others—about whether there are diseases or conditions (i.e., arthritis, diabetes) where we are close to a major breakthrough, which could be accomplished if we only had an infusion of additional research dollars?

Where would you target additional biomedical research dollars? By finding the cause and cure for which diseases or conditions would we make the biggest impact—in both human terms and on health care expenditures?

Dr. KAPLAN. A review of the known diseases and conditions which are the major causes of death and infirmity among the elderly give us our cues as to the directions for needed research dollars. With the dementias becoming increasingly known and with significant knowledge being added to the Alzheimer type I would urge a major effort be directed toward the Alzheimer disease. By itself this would also aid in providing other dementia knowledge.

I would also urge built up research movement in two other directions, namely, nutrition as related to both prevention and amelioration of the chronic illnesses in old age, and, suicide in old age. The latter has moved up as a leading cause of death. There are undoubtedly behavioral, sociological and biological components involved therein.

Appendix 2

LETTERS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER AND ENCLOSURE FROM WILLIAM H. McBEATH, M.D., M.P.H., EXECUTIVE DIRECTOR, AMERICAN PUBLIC HEALTH ASSOCIATION, WASHINGTON, DC, TO SENATOR JOHN GLENN, DATED OCTOBER 4, 1984

DEAR SENATOR GLENN: Thank you very much for informing us of the upcoming hearing on "Women in Our Aging Society." We appreciate your thinking of us.

Enclosed please find a copy of the American Public Health Association's position paper entitled, "Aging Women's Health Issues." We would like this paper to be submitted into the hearing record if possible. We trust you will find it of interest.

The Senate Special Committee on Aging is to be commended for addressing this important issue. We look forward to working with you in the future to address the special problems and concerns of the aged.

Very truly yours,

WILLIAM H. MCBEATH, M.D., M.P.H.

Enclosure.

AGING WOMEN'S HEALTH ISSUES

I. STATEMENT OF THE PROBLEM

The issues and impact of the health status of women in their middle age, 40 to 65 years, and on elderly women over the age 65 cut across all social class, racial, and ethnic segments of society. Once past the child-bearing years, all aging women experience similar vulnerabilities. American women have a life span of 77.3 years, almost eight years longer than men.[1] The United States population ratio projected for the year 2035 is 33.4 million women versus 22.4 million men. Gerontological and health research has addressed problems that impact on aging women.[2, 3, 4] Because of the longer life expectancy of women, the problems of the elderly are increasingly those of women.[5] Elderly women are vulnerable to such problems as poverty, nutritional deficiencies, functional dependency, emotional impairments, sex-role stereotypes,[6, 7] isolated social patterns,[8] hospitalization and permanent institutionalization.[9] Women of all ages accept negative environmental cues that reinforce negative images.[10]

The health concerns of aging women include those that affect older people in general as well as those specific to gender. Specific symptoms attributed to menopause

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[1] Verbrugg LM: Recent trends in sex mortality differentials in the United States. Women and Health 1980;5:17-38.

[2] Rice DP, Cugliani AS: Health Status of American Women 1980;5:5-22.

[3] Moore E: Women and Health. Public Health Rep (supplement) September/October 1980.

[4] Uhlenberg P: Older women: the growing challenge to design constructive roles. Gerontologist 1979;19:236-241.

[5] Federal Council on the Aging, US Department of Health and Human Services: The Need for Long-Term Care: Information and Issues. DHHS Pub. No. (OHRD) 81-20704, Washington, DC: US Govt Printing Office, 1981.

[6] Brower HT, Tanner LA: A study of older adults attending a program on human sexuality: a pilot study. Nursing Res 1979;28:36-39.

[7] Wasow M, Loeb MB: Sexuality in nursing homes. J Am Geriatric Soc 1979;27:73-79.

[8] Rathbone-McCuan E, Hashimi J: Isolated Elders: Health and Social Intervention, Rockville: Aspen Systems, 1982.

[9] Kassel V: Sex in nursing homes. Med Aspects Hum Sexuality 1976;10:126.

[10] Comfort A: Drug therapy and sexual function in the older patient. *In:* Comfort A (ed): Sexual Consequences of Disability. Philadelphia: G.F. Stickley, 1978.

and aging women,[11] such as hot flashes,[12] depression,[13] vaginal dryness, and osteoporosis,[14] have particular significance for older women. Cervical and breast cancer are two major forms of cancer which contribute to high rates of cancer-related deaths among older women. Breast surgery and hysterectomy, along with numerous other body-transforming procedures, take a significant toll on the woman's self-image. The different social roles and expectations placed on aging men and women come into play when women experience osteoporosis, Alzheimer's Disease, hypertension,[15] visual impairments,[16] and loss of mobility due to problems with the feet.[8] These disabilities threaten the independence of older women and impinge on the aged and ill family members for whom older women provide care. Women's use of drugs, such as anti-hypertensives, anti-cancer, and anti-Parkinson's medications, is often responsible for the development or aggravation of depression or similar symptoms.[17, 18] Older women who abuse alcohol may also abuse prescribed drugs.[19] Exercise and nutrition are important to both men and women, but self-images, supported by traditional roles and environmental expectations, affect older women's willingness to exercise and alter food preparation and dietary habits.[20, 21] Religious practices and spiritual values play a role in the life of older women.

Caregiving places aging women in the middle between the caregiving needs of older and younger generations of family members.[22, 23, 24] Personal costs to women providing care for others represent a difficult issue to balance with the benefits of their caregiving. The issues of social isolation within the caregiving arrangement, the economic costs associated with caregiving not compensated for and the lack of people to care for the elderly women, and the health risks produced for the caregiver are significant health issues of older women. Work, while essential for the economic functioning of older women and their families, is not associated with wage and salary equity between women and men. For women without education and vocational skills, employment does not eliminate poverty or assure access to health benefits. The types of jobs that older women hold often expose them to specific health risks, such as those present in the electronics industry,[25] asbestos product factories,[26] health care industry,[27] and in various clinical positions.[28]

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[11] Delorey C: Health Care for Midlife Women. (Doctoral dissertation.) Boston: Harvard University School of Public Health, 1980.

[12] Voda AM: Menopausal Hot Flashes. Paper presented at American Psychological Association Meeting, Montreal. Minneapolis: University of Minnesota School of Nursing, 1980.

[13] Weisman MM, Klerman GL: Sex differences and the epidemiology of depression. Arch Gen Psychiatry 1977;34:98–110.

[14] Johnson RE, Specht EE: The risk of hip fracture in post menopausal females with and without estrogen drug exposure. Am J Public Health 1981;71:138–144.

[15] Kannel WB, Gordon T: Cardiovascular risk factors in the aged: The Framingham Study. Haynes SG, Fienleib M, Ross JA, Stallones L (eds): *In:* Epidemiology on Aging. NIH Pub. No. 80–969, Washington, DC: Govt Printing Office, 1980.

[16] Peterson R, Lowman C, Kirchner C: Visual Handicap: Statistical Data on a Social Process. J Visual Impair Blindness 1978;72:419–421.

[17] Zlance RT: Side effects of drugs in the elderly. *In:* Peterson DM, Whittington FJ, Payne BP (eds): Drugs and the Elderly. Springfield: Charles C. Thomas, 1979.

[18] Blumenthal M: Depressive illness in old age. Psychiatry 1980;35:34–43.

[19] Rathbone-McCuan E. Roberds L: Treatment of the older female alcoholic, focus on women. J Addict Health 1980;1:104–129.

[20] Warner-Reitz A: Health Lifestyles for Seniors: An Interdisciplinary Approach to Health Aging (Program Development Manual). Santa Monica, CA: Meals for Millions/Freedom from Hunger Foundation, 1981.

[21] *Menopause: A Natural Process.* San Francisco: San Francisco Women's Health Center, 1980.

[22] Brody EM: Women in the middle—family help to older people. Gerontologist 1981;21:471–480.

[23] Fengler AP, Goodrich N: Wives of elderly disabled men: the hidden patients. Gerontologist 1979;19:175–185.

[24] US Department of Labor: Mature Women Workers: A Profile. Washington, DC: US Govt Printing Office, 1977.

[25] Stellman JM: Women's Work, Women's Health: Myths and Realities. New York: Pantheon, 1977.

[26] Chmielewski J: Respiratory tract in subjects occupationally exposed to asbestos dust. Medcyna Pracy (Lodz) 1979;30:375–380.

[27] Women's Health, Women's Work 1980. New York: Women's Occupational Health Resource Center, 1979.

[28] Benjamin RR: Occupational Health Needs of the Older Woman. (Unpublished paper) New York: Columbia University, 1981.

II. PURPOSE

The purpose of this position paper is to: (1) Establish a clear policy of the American Public Health Association (APHA) on the health issues of older women; (2) establish a strategy for planning and delivering health and social services to this population; and (3) clarify directions for research. Issues concerning long-term health care and general health issues of older women have been addressed previously by the APHA.[29, 30, 31, 32] Also, such organizations as the National Institute on Aging, National Institute of Mental Health, Administration on Aging, Older Women's League, and Gerontological Society of America have identified older women's concerns. Numerous recommendations have been proposed; however, no national professional organization has proposed a comprehensive prevention and intervention strategy. Such a strategy would address myths and stereotypes, gender-specific health issues, unique impacts of the aging process, demands on women as caregivers, occupational health risks, and specific research and policy deficiencies. The strategy must conceptualize aging women to include mid-life and late life, respond to the double jeopardy of agism and sexism, reflect a holistic perspective, respond to high-risk subgroups of older women, and identify solutions that strengthen informal caring and integrate it with formal resources. A comprehensive strategy is necessary to respond to the growing crisis of resource shortages in the face of expanding numbers of older women. The APHA is in a position to formulate and support a strategy because of its: (1) Public policy positions on numerous problems impacting on both women and the elderly; (2) multidisciplinary and professional membership expertise, skills, and commitments related to health and social issues that impinge on older women; and (3) leadership role in national, state, and local health planning.

III. OBJECTIVES

The planning and implementation of a strategy to address the health issues of aging women implies the need for research, education, resource coordination, legislation, advocacy, and insurance. The initiative now begun must reflect an awareness of: (1) The needs of every elderly woman whose risks are immediate and linked to current long-term care issues; (2) the potential problems of women chronologically old but currently functioning at a high level until they experience health and economic deficits; (3) the circumstances of middle-aged women dealing with life transitions and managing needs of dependent people; and (4) the younger women with future needs to prepare for and cope with during the aging process of their families. A response to the health needs of older women must incorporate a futuristic orientation balanced with the imperatives of the present. It should respond to ethnic, social, lifestyle preferences, geographical, and other factors which create specific risks.

In preparation for planning a current and future strategy, certain broad priorities must be matched with a comprehensive research agenda, educational efforts, resource coordination mandates, and advocacy programs.

A comprehensive research agenda should incorporate the normal aging process and pathological models as well as encompass biomedical, applied health care, social science, and clinical intervention research. All types of research have neglected to design studies that gather adequate data about all female samples; comparisons between older men and women and between younger and older women; and subgroups of older women. In studies where such data have been collected, information related to older women's concerns is either only partially analyzed or not readily assessible in published form. New analytical procedures may need to be applied in order to produce more reliable documentation of the interactive influences of age and gender variables. Health survey research and program design and outcome studies need to be increased in number and scope.

An educational strategy should encompass the spectrum of health professionals and multiple levels of educational preparation as well as continuing education. Sig-

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[29] APHA Public Policy Statement 8131: Toward a National Policy on Long-Term Care for the Aging. APHA Public Policy Statements 1948–present, cumulative. Washington, DC: APHA, current volume.

[30] APHA Public Policy Statement 7323: Home Health Services: A National Need. APHA Public Policy Statements 1948–present, cumulative. Washington, DC: APHA, current volume.

[31] APHA Public Policy Statement 7010: Home Health Care. APHA Public Policy Statements 1948–present, cumulative. Washington, DC: APHA, current volume.

[32] APHA Public Policy Statement 8201: Health Issues of Older Women. APHA Public Policy Statements 1948–present, cumulative. Washington, DC: APHA, current volume.

nificant educational advances in medical, nursing, social work, and other key professions mark a shift toward more gerontological and geriatric content. To date, however, much of the curricula content is void of gender-related information. Clinical training often fails to reduce myths and stereotypes held by practitioners. The focus of education should transcend the narrow pathological/disease perspective and move toward an understanding of function and dysfunction within a broader environmental perspective. Economic resources to support appropriate gerontological and geriatric education should be distributed evenly among liberal arts, technical and professional fields, and enhance both quality of pre-professional training and professional continuing education. Also, women's health educational information should be broadened to include aging women.

A resource coordination strategy should involve better integration of the service delivery systems that provide direct and indirect functions to older women. Frequently, health, mental health, aging, and women's programs are not coordinated with ongoing programs. Divisions of public and private sponsorship are often barriers to outreach and service plan management. More third-party reimbursement resources need to be available to support new community care systems that are being demonstrated and evaluated for preventive, acute, and long-term care.

An advocacy strategy should include the aging women's health services and also encourage objectives of health promotion and care for women across the life span. Direct attention to gender-related issues in the provision of services to older persons can only benefit, not harm, the overall population of older Americans. The preparation of older women's health advocacy efforts must draw upon the strength of older women and encourage direct leadership roles among minority older women whose contributions are central to a meaningful advocacy process.

IV. DESIRED ACTIONS AND RECOMMENDATIONS

The essential steps for APHA to take include:

—APHA should actively encourage future reauthorizations of the Older Americans Act, with special attention to congregate meals, meals-on-wheels, and employment opportunities for older women, as well as a mechanism for funding research and demonstration projects.

—APHA should encourage all relevant federal agencies to include the health of older women as a research priority and to fund projects that contribute to theory and service application as well as exchange information about ongoing projects.

—APHA should support the development of educational content about older women's health and inclusion as part of public health and gerontological curricula.

—APHA should communicate actively with federal and state units of government about the health promotion and care needs of older women; and

—APHA should support the emerging national advocacy movement for and by older women.

V. METHOD OF IMPLEMENTATION

The issues presented in the position paper will be summarized and distributed to key federal agencies and congressional committees. Letters will be written to directors of state public health and aging services. Information will be disseminated to major university gerontology programs and to schools of public health. APHA sections and caucuses will continue and increase current efforts to link and monitor developments within the older women's advocacy movement.

ITEM 2. LETTER FROM SENATOR NEAL F. ZIMMERS, JR., COLUMBUS, OH, PRESIDENT PRO TEMPORE, STATE OF OHIO SENATE, TO SENATOR JOHN GLENN, DATED OCTOBER 9, 1984

DEAR JOHN: Thank you for inviting me to attend the U.S. Senate Special Committee on Aging hearing yesterday in Columbus. My aide, Gael O'Brien, represented our office. I am very interested in the hearing topic "Women in Our Aging Society."

You may be aware that I am chairing an Ohio Senate Task Force on Women Single Heads of Households to determine what possible State, Federal, and private sector initiatives will help change the aspects of current public policy that present obstacles to women struggling to support their families.

Elderly women and women single heads of households with dependent children share a disproportionate place in the poverty population. In Ohio, according to 1980

census data, over 40 percent of women heads of households in Ohio are poor and 50 percent of children under age 18 living in households headed by women are living in poverty.

From July 10 to October 1, the Ohio task force held six hearings and took testimony from about 140 women single heads of households. I plan to issue a report of findings and recommendations by early January and will certainly give you a copy.

In reference to yesterday's presentations, which I understand were excellent, I would like to respond to your question about the adequacy of job training programs in Ohio. The JTPA is received very mixed reviews in reference to job training for women. Displaced homemakers are only one of several targeted groups in the 3 percent set-aside for older displaced workers. Job training and training for jobs that exist and aren't just entry level are of vital importance in providing the possibility for economic survival for women both as single heads of households and when they are senior citizens.

I hope you and I will have an opportunity to discuss these and other issues in the near future.

Best regards,

NEAL F. ZIMMERS, Jr.

Appendix 3

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing, a form was made available by the committee to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

DEAR SENATOR GLENN: If there had been time for everyone to speak at the hearing on "Women in Our Aging Society," in Columbus, OH, on October 8, 1984, I would have said:

The following are excerpts from the 200 replies received:

PATRICIA BARRY, DIRECTOR, OHIO DEPARTMENT OF HUMAN SERVICES

The Ohio Department of Human Services, through its agents, the county departments of human services, provides a full range of social services, including legally mandated protective services to elderly women. Federal funding for these programs is limited to a share of the title XX block grant of the Social Security Act. What is needed in our judgment is a separate adult welfare act under the Social Security Act. This public system in concert with the aging network funded by the Older Americans Act will more successfully provide the continuum of care which women in our aging society require and deserve.

RITA BENNETT, COLUMBUS, OH

A particularly impressive aspect of your hearing is the "multi- or intergenerational" theme. Our society has often become culturally and emotionally "fragmented"—with conflicts and frustrations because of so-called "special interests"—rather than a supportive network focusing on "mutual interests." The conflicts are caused, I believe, from a sense of isolation and alienation. Programs and services need to be developed to reinforce and assist people to be supportive of other generations (younger and older). For example, child care resources should be viewed as congruent with Medicare allocations.

JUDITH CARR, M.S., R.N.C., PLEASANTVILLE, OH

Medicare reform should include fees for home care by nurses for elderly people who are no longer acutely ill but are in need of "preventive illness occurrence" and/or maintenance care. Currently, once a person becomes stable by Medicare standards the person's care is no longer covered. My suggestion would be to increase payments for R.N. care to elderly for maintenance and wellness promotion activities. Second, provide for more home health aide and homemaker services for elderly. Third, increase respite services to families and neighbors who are assisting and supporting the elders' daily care. As mentioned, this directly affects elder abuse as a prevention strategy.

Medical research for diseases should only be a small part—we need research on social, nutrition, wellness or health maintenance, value and cultural strategies. Also, we do know enough in many areas to proceed to act, such as in the area of respite care.

JUDITH A. DAVIS, ZANESVILLE, OH

I have my master's degree in nursing and will soon be enrolling in some continuing education courses in gerontology. (I have only become interested in this since

becoming 40 years old.) I think it will be difficult to interest young doctors and nurses in nursing homes and care of geriatric patients because these patients represent a "multiplicity of health problems" in whom change or recovery is followed only by development of another problem. Young doctors and nurses generally do not choose geriatrics because they like to see a quick and rapid recovery and discharge of the patient from the health care system. I believe we need more continuing education programs for mature doctors and nurses already in the work force. There are relatively few of these programs in existence. I checked out a number of colleges before I found a "certificate program in gerontology" at Ohio Dominican College in Columbus, OH.

NANCY E. SMITH EVANS, PH.D., AMERICAN ASSOCIATION OF UNIVERSITY WOMEN, COLUMBUS, OH

The positive presentations today will assist in garnering support for the changes needed in our society. From a more personal perspective, it was a joy for me to listen to these speakers with my mother. The issues discussed, the potential solutions exposed, and the hopeful atmosphere created have pinpointed the concerns (many as yet not discussed) which our family will be facing.

Thank you.

KAY R. FLOOD, COORDINATOR, DISPLACED HOMEMAKERS, PYRAMID CAREER SERVICES, CANTON, OH

A type of group insurance policy is needed that can be made available for women who lose their benefits when they divorce or are widowed. This could be a policy that the woman pays premiums for, but the premiums need to be affordable. Ohio has a law that permits women to continue on their ex-husbands' medical insurance through premium payments. The law permits but very few women are able to avail themselves of it because companies do not cooperate, thus women must pay very high premiums or do without health care insurance.

DOROTHY S. LONGAKER, KNOX COUNTY DEPARTMENT OF HUMAN SERVICES, MT. VERNON, OH

We are trying to establish an adult day care center in our county. The barriers to this include lack of guidelines (State or Federal) and no Federal, State, or local funds to apply for—instead we must try to get a piece of the dwindling title XX pie and other sources that have already been cut back or which are already completely "sewn up" in the bureaucracy that exists in aging funding. Although I understand that innovative programs are not being funded these days, somehow things must be turned around to meet the growing needs of a growing aging population.

WALLACE MCDOUGALD, JR., COLUMBUS, OH

I would like to comment on your statement regarding "homemakers versus institutional living." My personal feeling is that homemakers could provide a valuable service to senior citizens. Allowing senior citizens to continue to live in their own homes, a place that has many wonderful memories, appears to me to give the senior citizen a will to continue to live and be productive. Moving into a nursing facility does provide a needed service to those that require such service, but this requires an adjustment period that is difficult. I hope in the future, senior citizens will have the choice between a homemaker and living in a nursing facility, whichever provides the service that they need.

DR. BARBARA NELSON, OHIO STATE UNIVERSITY, COLUMBUS, OH

I am concerned about the effect on middle-aged women in the coming years. They will have an increasing load of care-giving for husbands and parents at a time when it is essential that they establish their own leisure, health, and self-growth patterns for their own old age. These women face an emotionally and financially draining experience.

I'd like to investigate means of supporting women during this period and helping to assure that they have the health and energy and will to continue to be contributing members of society.

It is important to prepare for a life good to live, not just to remain living imprisoned by care-giving, diminished resources and reduced self-esteem and social network.

BARBARA PATS, COLUMBUS, OH

I think it is also important to be aware of how proud many of these older women are of their independence and that admitting they need help is very difficult for them. Programs and helpers need to act sensitively to these women and keep in mind their feelings and pride. We need to remember older people are human and respect them.

BOB PROUD, CLERMONT SENIOR SERVICES, INC., CINCINNATI, OH

In reference to the suggestion of offering courses in gerontology for medical schools and other colleges and universities, I'd like to suggest taking it to lower levels of education. Perhaps classes in gerontology at high school and elementary levels could be offered. At least some exposure to older persons should be required. Why wait till people get into college to offer exposure to the elderly when it is while they are young that stereotypes of the elderly are developed.

ROSEMARY RENGERS, COLUMBUS, OH

We need to develop ways to retrain or train women in their middle and later years, in some of the newer technologies, i.e., computers and word processing.

Why can't women, 50-plus, attend classes free (or on a sliding scale) at vocational schools. It would be very helpful, especially to those who are widows or displaced homemakers.

LOUISE T. ROBINSON, WORTHINGTON, OH

I am grateful that voting and registration standards have changed to allow for the aged and handicapped to be able to fully participate in the voting process.

I had an older friend who was so sad when her infirmity would not allow her to accomplish the steps to her voting place, and regulations were too difficult on absentee voting in Ohio. She was so glad when regulations were loosened to accommodate voters without physical alacrity.

PEGGY SEBASTIAN, OHIO STATE UNIVERSITY, COLLEGE OF SOCIAL WORK, COLUMBUS, OH

Thanks so much for having the hearing in Columbus. As a third generation older woman (my grandmother is 95; mother is 77) of this State, I would like to draw attention to the potential contribution of the army of retired women who have years of valuable experience in responsible public and private organizations. Many of these women are interested in earning extra money or at least utilizing their skills and experience on a part-time basis. Senior placement bureaus as we have in Columbus are a very valuable resource to both the older women and the communities they live in. The recent Senior Job Fair in Columbus was an illustration of this kind of activity.

DORIS H. SWABB, KETTERING, OH

Counseling for women re-entering the work force is always helpful and often necessary. I was lucky—my husband wanted me to go back to school. What about those who have slight or no support for their efforts?

RUTH L. WILLIAMS, COLUMBUS, OH

Many black families stretch their already overburdened financial resources to care for elderly relatives. In many cases, public assistance such as food stamps and

State aged assistance are denied because of a method of computing family income as one family rather than two families. Many times, both parents are living with a young family. I urge legislation that will encourage extended families as both an alternative for the aged and as an alternative for increasing day care centers for children. I support programs which give support for families caring for the dependent elderly such as day care centers, home nursing care, visiting medical support persons to take blood pressure and administer medication.

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